Edgbaston Healthcare Limited

Melville House

Inspection report

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Date of inspection visit:
30 April 2019
01 May 2019

Date of publication:
20 June 2019

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service: Melville House is a nursing and residential care home that provides personal and nursing care to up to 29 people. There were 26 people living at the service at the time of the inspection. Most of whom were older people living with dementia.

People's experience of using this service:

People were not sufficiently protected from the risk of harm; including potential abuse, the behaviour of others, health concerns or accidents and injury. The provider's risk management systems were inadequate. People were not protected by safe medicines management systems.

People were not being supported by sufficient numbers of staff with the right skills that were being deployed effectively.

People's rights were not upheld with the effective use of the Mental Capacity Act 2005. People's needs were not being accurately assessed, understood and communicated. Care provided did not consistently meet people's needs. People were not receiving care that was truly person-centred and met all of their needs; including religious needs and leisure.

People did not receive support that was consistently caring and respectful that upheld and promoted their dignity and independence.

People were not protected by robust quality assurance and governance systems. The provider failed to ensure the systems they had in place identified risk to people and areas of improvement needed. The provider failed to make sufficient improvements and as a result people were living in a deteriorating service and were exposed to the risk of harm.
Rating at last inspection: At the last inspection the service was rated 'requires improvement' (inspection completed 22 February 2019 and report published 01 May 2019). The service has been rated as requires improvement seven times prior to this inspection.

Why we inspected: We completed this inspection due to our previous inspection findings and ratings in addition to concerns that were received from the public and local authority. The inspection was brought forward due to information of concern regarding the quality of care being provided to people.

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

Follow up: Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made

significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

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.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our Safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our Effective findings below.	**Inadequate**
Is the service caring? The service was not 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. Details are in our Well-Led findings below.	**Inadequate**

Melville 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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection team consisted of two inspectors, an assistant inspector and an expert-by-experience (ExE). An ExE is a person who has personal experience of using or caring for someone who uses this type of care service.

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

The service did not have a manager registered with the Care Quality Commission. A manager had been appointed and they were in the process of applying to become the registered manager. The registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
The inspection took place on 30 April, 01 May and 09 May 2019. The first day of the inspection was unannounced and the provider was aware we would returning on 01 May 2019. We completed a third, unannounced day of inspection to check to see if the provider had carried out specific actions they told us they would make to keep people safe from harm.

What we did:
As part of the inspection we reviewed the information we held about the service. We looked to see if statutory notifications had been sent by the provider. A statutory notification contains information about

important events which the provider is required to send to us by law. We reviewed information that had been sent to us by the public. We used this information to help us plan our inspection.

During the inspection we spoke with seven people who used the service and two relatives. Many people who lived in the service were unable to share their views regarding the care they received. To help us understand the experiences of these people we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people living at the service. We also carried out further observations across the service regarding the quality of care people received. We spoke with the provider, the manager and nine staff members including the cook, activities co-ordinator, nursing staff, senior care staff and care staff. We reviewed records relating to people's medicines, people's care records, including nine people's care records in detail. We also reviewed records relating to the management of the service; including staff recruitment records, complaints and quality assurance records.

Inadequate

Is the service safe?

Our findings

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

Inadequate: People were not safe and were at risk of avoidable harm. Some regulations were not met.

At the last inspection completed in February 2019 we found the service to be 'requires improvement' for this key question. At this inspection we found the quality of care had deteriorated and people were at risk of harm. They were not meeting the requirements of the law.

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

- Some people living in the service told us they did not always feel protected from the behaviour of others within the service. One person told us, "[Person's name] put his fist up and was going to whack me. [Person's name] threatens staff as well." The management team told us they were not aware of this incident. We reported the concern to the local safeguarding authority for investigation.
- We confirmed multiple people in the service had demonstrated behaviour that could cause physical or emotional harm to staff or other people in the service, including the person outlined above. We found some basic 'challenging behaviour' care plans and risk assessments had been developed although these had not been sufficient in managing the risk. Staff we spoke with were not aware of potential 'triggers' for behaviours and how these could be used to prevent situations from escalating. Staff demonstrated a lack of understanding around how to protect people; with one staff member telling us they just 'monitored' the behaviour of one individual known to hit others.
- We also found two people who lacked capacity were displaying sexualised behaviour. No action had been taken to manage any potential risk of harm to either these individuals or to others living in the service.
- People were not protected from the risk of harm due to accident and injury. For example; where people were identified to be at risk of falls they did not take steps to ensure these people were protected as far as reasonably possible. One person who required supervision while mobilising was seen to be struggling to mobilise independently, using walls and furniture for support. Another person had been advised to complete physiotherapy exercises several times a day and the person was not receiving the support they required to carry these out. On some days the exercises were completed once and on others not at all. This meant the required treatment to increase strength and reduce the risk of further falls had not been completed.
- We found the provider had failed to ensure that risks associated with people's dietary needs were safely managed. For example; Speech and Language Therapists (SaLT) had confirmed one person should be seated in an upright position while eating and drinking to prevent the risk of them choking or aspirating on food. We saw this person slumped in a chair and coughing while eating. Staff and management we spoke with were unaware of this instruction. We also found another person's social worker had completed an assessment that stated they should eat a soft diet and be supported to eat by staff. This person was eating a normal textured diet without support. Again, staff and management were not aware of this instruction. We referred these concerns to the local safeguarding authority for investigation.
- Where incidents had arisen either nationally or locally the provider failed to use these to learn lessons to minimise any future risks within the service. For example; despite national warnings issued about the fire

risk associated with paraffin based creams, the provider had stored these creams in a bedroom of a person using oxygen with no warning signs and near to where a person was smoking. We also found the provider failed to take sufficient action to mitigate against future incidents and failed to analyse incidents for any trends or patterns that may help them to protect people in the future.

The provider's failure to assess and mitigate against risks to people was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

Using medicines safely

•□We found medicines management systems were not always safe. People were not always administered their medicines as prescribed and monitoring systems were not robust.

•□People who were prescribed topical creams did not always receive these in line with prescribing instructions. We found multiple people were not receiving their creams at the frequency required and these people did not have capacity to identify when their creams may be needed.

•□Some people receiving who lacked mental capacity were being administered 'as required' medicines with a sedating effect on a regular daily basis. These medicines should only be administered when there is a clearly identified reason. Staff were not able to provide an explanation and there was no documented reason for this frequency of administration.

•□We also found the provider had failed to ensure the storage of medicines was safe. We found the temperature of the medicines storage room had exceed the maximum recommended temperature on multiple occasions during the month of April 2019 and no action had been taken.

The providers failure to ensure medicines management systems were safe was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

Systems and processes to safeguard people from the risk of abuse

•□Staff we spoke with were able to describe basic signs of potential abuse and how they would report concerns.

•□The management team did report safeguarding concerns to the local safeguarding authority when they were identified. However, poor risk management systems and a lack of robust safeguarding knowledge amongst the staff and management team meant that concerns were not always identified.

•□For example; we identified concerns that had not been reported to the local safeguarding authority involving incidents that indicated specific people could pose a risk to others in the service. As a result of these incidents, people did not always feel safe. One person told us, "I lock my room at night".

•□The provider had failed to ensure their systems around risk management, reporting and learning from incidents were robust and protect people from the risk of ongoing harm.

Staffing and recruitment

•□People we spoke with told us there were not always enough care staff to support people. One person told us, "No there have never been enough staff. They come and go. New staff come in, they see what this place is like, and soon leave." Another person told us, "You can't expect miracles from [the staff]. They're short staffed. They're doing the best with what they've got."

•□We saw while there was a reasonable ratio of staff to people in the service the provider, the provider had failed to assess whether the number of staff available was appropriate to meet people's needs. They had failed to formally assess the number of staff and the skills required to support people. They had not considered the high dependency levels of people in the service, the skill set or roles of working staff members or the deployment of staff across the unique layout of the building, including multiple floors and multiple communal areas.

•□We found there was just one nurse working on each shift to support twenty-five people we were told by staff had nursing needs. We also saw there was a high number of agency staff working during the inspection. These factors had not been considered by the provider and they had not assessed whether these staffing arrangements meant the staff team had the appropriate skills, experience and knowledge required to support people safely.
•□We saw some people potentially at risk due to the lack of staff available to provide supervision or support. For example; people at high risk of falls attempting to mobilise without appropriate support.
•□We found basic pre-employment checks such as identity checks, reference checks and Disclosure and Barring Service (DBS) checks had been completed prior to staff members starting work. However, we did identify some concerns with the robustness of some reference checks..

Preventing and controlling infection
•□During the inspection we saw basic infection control practices in place; such as domestic staff cleaning and staff using Personal Protective Equipment (PPE).
•□We found some concerns with infection control practices including hand soap having run out in the staff toilet and the provider failing to ensure this was refilled for a full 24 hour period.
•□The decoration and maintenance in the service was below the expected standards and as a result we found some areas of the service were not clean, despite domestic staff having cleaned. For example; walls in the main dining room area were mottled with unidentified stains and appeared unclean.

Inadequate

Is the service effective?

Our findings

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

Inadequate: There were widespread and significant shortfalls in people's care, support and outcomes. Some regulations were not met.

At the last inspection completed in February 2019 we found the provider to be rated as 'requires improvement' for this key question. At this inspection we found the service had deteriorated and the provider was now 'inadequate' and failing to meet the requirements of the law.

Supporting people to live healthier lives, access healthcare services and support

- People were supported to access healthcare professionals such as doctors, dentists, chiropodists and mental health professionals. However, this was not always done in a prompt and proactive way.
- We found one person had been losing weight since the summer of 2018 and a referral to a dietician had only been made in the week prior to our first day of inspection. We found a doctor had recommended a referral to mental health professionals in December 2018. The person had been experiencing significant symptoms of a mental health condition although the service failed to chase this referral therefore no support had been made available to this individual for over four months.
- Where people's capacity impaired their ability to make safe choices in relation to their health, the provider failed to ensure appropriate healthcare intervention was in place. For example; staff told us one person supported themselves in relation to dental care and their care records reflected this. We found this service user to have very poor dental hygiene and were told by some staff this service user lacked capacity and this was in line with our own observations. Staff had failed to take steps to support the person to maintain good dental hygiene.

The provider's failure to ensure people were supported to live healthy lives and access healthcare support promptly put them at risk of harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

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 with appropriate legal authority. 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 any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

•□We found staff had an inadequate knowledge of the MCA. They did not understand how to assess people's capacity in line with the law or how to make best interests decisions when people did not have the capacity to make their own choices or provide consent.
•□Some staff we spoke with did not understand that people had the right to make unwise choices if they had the capacity to do so. They told us they would make a decision for the person they felt was right for them. This would be a breach of the person's rights.
•□We found decisions were being made on behalf of people who lacked capacity without the principles of the MCA having been followed. These included the use of equipment such as sensor mats, changes to their diet including the introduction of texture modified diets and the administration of medicines. We identified two people were being given sedating medicines daily that had been prescribed on an 'as required' basis. This meant these medicines should only be given when needed and a reason for the administration should be documented. Staff could not provide an explanation as to why the medicines had been administered and there were no documents available to support this.
•□The manager had stated they felt issues relating to the MCA identified at prior inspections had now been resolved. We found this not to be the case.

The provider's failure to ensure the requirements of the MCA were being met was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Need for consent.

•□We found DOLS applications had been submitted to the local authority as required by law to deprive people of their liberty in order to protect their health and wellbeing.
•□We found one person had specific conditions outlined in a DoLS that had been granted by the local authority. Staff we spoke with were unaware of both who had a DoLS granted, who had an application in process and if there were any conditions on any granted DoLS. This meant staff were not proactively ensuring the conditions specified were being met.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care
•□We saw assessments were being completed prior to a person moving into the service for the first time. However, we found these assessments were not always adequate in identifying people's needs and preferencs.
•□We found a senior member of care staff was completing assessments of people's needs; even where these needs were of a nursing nature and clinical knowledge may be required. As a result specific needs were often not identified. For example; the assessment completed by the service for a person whose social worker had identified them as being at high risk of falls and requiring a specialised diet did not address these needs. We found the care delivery provided also did not meet these needs. The provider failed to ensure they had worked effectively with the social worker to ensure the person received safe, effective care that was consistent with their previously identified needs.
•□Care plans also did not translate into the care and support actually provided. Staff often did not have a working knowledge of people's care plans and risk assessments.

Staff support: induction, training, skills and experience
•□People and relatives we spoke with gave us mixed views around the skills of the staff supporting them. One person told us, "90% of [staff have the skills needed], yes". We saw this reflected in the care we saw delivered during the inspection. While some staff had effective skills when supporting people, others did not.
•□The manager gave us a training matrix that showed most staff had received basic training but this was not consistent. For example, we saw some staff had received safeguarding training in April 2019 although three staff members had no safeguarding training listed at all. This was an area in which we found staff to have

insufficient knowledge.
•□We also found some staff had received MCA training in April 2019, although one staff member had not received training for nearly five years and four others not at all.
•□We found while some competency checks and observations of staff were completed by the manager these were not effective. They failed to identify the concerns we found during our inspection and did not result in action being taken to drive improvement.

Supporting people to eat and drink enough to maintain a balanced diet
•□People gave us mixed views around the food they received. One person told us, "On the whole it's reasonable, but I can't say it's good."
•□We saw people were given some basic choices around the type of food they wanted to eat and alternatives were made available where necessary.
•□The cook had a good understanding of the information they had been given by the care team around people's needs. However, we had some concerns about the accuracy of some of the information provided to the cook.
•□We saw some concerns around the refusal of food and weight loss had not been acted on proactively. Care and nursing staff also had inconsistent knowledge around people's needs including those on texture modified diets and those with diabetes. This meant people were at risk of becoming unwell as staff were not aware of the supported they needed to maintain their health.

Adapting service, design, decoration to meet people's needs
•□People told us they felt the building was not appropriate to meet people's needs and required improvement. One person told us the building was, "Lousy, terrible. It's [just] two houses banged together… The bedroom is basic with a sink in it and that's it." Another person told us, the building was not suitable for people trying to mobilise with walking frames or wheelchairs.
•□The provider had not considered people's needs and used this information as a basis for ensuring the design and adaptation of the building continued to meet people's changing needs. For example; there were not sufficient dining tables and chairs for people who did not want to eat in their bedrooms. There were no private spaces for people to spend time with their family and friends.
•□The decoration of the building did not meet best practice guidelines for people living with dementia.

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

Inadequate:People were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls and some regulations were not met.

At the last inspection completed in February 2019 we found the provider to be rated as 'requires improvement' for this key question. At this inspection we found the service had deteriorated and the provider was now 'inadequate' and failing to meet the requirements of the law.

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

- People told us while some staff treated them well others were not kind and caring in their approach. One person told us, "Most of them are nice but you do get the odd one. If I didn't have this place I'd have no place to go – I'd be out in the street." They told us they felt they had to 'put up' as the service was where they had to live. Another person told us they felt staff did not always care and just wanted to come to work to earn money.
- The provider failed to ensure people's dignity was upheld within the service and failed to take proactive steps to protect people. During the inspection we saw one person in a communal area of the home with no clothes on. Prior to this event, a person told us this person regularly got confused and would walk out of their bedroom with no clothes. Some staff also told us this was a regular behaviour while others told us they were not aware of this concern. Staff were not able to outline how they had attempted to protect the dignity of this person or the guidelines in place. The person's care plan also did not contain guidelines around how staff should try to protect their dignity. We raised this concern with management and checked to see what action had been taken on the final day of our inspection. The provider told us they were not required to act they felt the incident we observed was the first and last time this had happened. This was not in line with our findings and the provider failed to take the opportunity given to put guidelines in place to protect the person moving forward.
- One person told us they were 'desperate' to have a shower as they had not been able to wash their hair in some time. We saw multiple service users in communal areas with dirty, stained clothing and looking like their personal hygiene and appearance was neglected. As a result we looked at personal care records and found multiple service users who lacked mental capacity had personal care charts confirming they were not receiving regular baths or showers. Care plans also lacked information around people's preferences in this area.
- We saw further examples of people's dignity being compromised and them not being treated with respect. For example; staff members were seen laughing when someone came to them confused and staff failed to take consistent proactive action when people were shouting in distress. We also saw people using toilets with doors open and no staff support.
- We found the lack of independence people experienced also compromised their dignity. For example; one person was seen microwaving a cup of water from the sink in the toilet first thing in the morning on the

first day of the inspection as they were not able to access a drink while another person was shouting about the lack of refreshments they had received that morning. We saw other people struggling to mobilise independently due to the lack of support provided. Including one incident when one person was using a chair to help themselves from moving which resulted in the person using the chair who had a visual impairment to be startled and resulted in an altercation.

•□We found the management of the service did not foster a culture that promoted the dignity and respect of people living in the service. For example; the manager offered the inspection team the use of someone's private bedroom to use as a meeting room. They subsequently offered to move people from a communal lounge. This demonstrated a lack of understanding of the importance of respecting people's home environment and their private space.

The provider's failure to ensure people were treated respectfully and that their dignity and independence was promoted was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Dignity and respect

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

•□We saw staff offering basic choices to people during the inspection. Although staff did not have an understanding around what a good, person-centred culture should look like and had not received training in this area.

•□For example; the lack of understanding of care staff around the MCA meant some staff felt they could make certain decisions on behalf of others where they did have capacity and choices may be considered inappropriate or unwise. Staff also did not ensure they were following the principles of the law where people lacked capacity to make choices.

•□While we were told people were supported with communication aids such as picture cards we did not see these in use during our inspection.

Inadequate

Is the service responsive?

Our findings

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

Inadequate: Services were not planned or delivered in ways that met people's needs. Some regulations were not met.

At the last inspection completed in February 2019 we found the provider to be rated as 'requires improvement' for this key question. They were failing to meet the requirements of the law. At this inspection we found while some action had been taken to address the issues identified with person-centred care, these were insufficient, they continued to fail to meet the requirements of the law and further improvements were still required.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

- People we spoke with told us they had not been involved in the development of their care plan. This was reflected in our observations during the inspection and care documents we reviewed. Although we saw regular reviews were documented involving people and their relatives.
- We found care plans did not contain detailed information about people's individual preferences; including personal care needs and their needs in relation to their leisure and wellbeing. Our observations and findings during the inspection demonstrated that people's needs were not fully understood and met.
- We found staff were not aware where specific information was included in care plans. For example; one person's care plan outlined they required an optical prescription. Their prescription confirmed their eyesight was poor without glasses. This person was not able to communicate verbally and staff were unsure of their mental capacity. Staff we spoke with were not aware the person had a prescription and glasses had not been made available to the person. This could have had a significant impact on the person's quality of life.
- People told us their personal interests had not been explored and there were not sufficient activities taking place or sufficient access to leisure opportunities. One person told us, "There's nothing to do. They [staff] have no time to stop and talk to you". Another person told us, "There are no facilities to do anything. You are expected to sit in the chair and look outside the window or stare at the TV. There is nothing for the residents." They also told us, "It's sheer boredom, there's nothing to do. I have no friends and no one to talk to."
- We saw the provider had recruited a part-time activities co-ordinator following our last inspection and they were completing organised activities during the inspection. However, there was minimal engagement in activities completed and they had not yet developed a plan of activities based on people's individual preferences and life history. We saw people continued to sit in communal areas for extended periods of time without any interaction from staff.
- We saw people's religious needs had not always been considered. For example; one person's social worker had outlined the importance of their religion to them and staying in contact with key people from their faith group. Staff we spoke with were unaware of these needs and there was no reference to this in their care plan or indication from care records that this need had been met.

The provider's failure to ensure that people's individual needs were fully understood and met was a

continuing breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person centred care.

End of life care and support

- We found basic end of life care plans were in contained in people's care plans. However, these plans did not contain information about people's personal preferences and wishes for the end of their life. For example, care plans did not address things such as the environment or who they would like to have present.
- One person was thought to be approaching the end of their life and was residing in a shared room at the service. We asked staff what consideration had been made to the person's own dignity for the final days of their life or the potential distress to the person sharing the room. These factors had not been discussed or considered.

The provider's failure to ensure that people's end of life wishes were known and understood formed part of a continuing breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person centred care.

Improving care quality in response to complaints or concerns

- People gave us mixed views around whether they felt able to raise a complaint. One person told us they would yet another said not.
- We saw complaints systems were in place however these had not been made accessible inline with the Accessible Information Standard which is a requirement care providers are required to meet.
- The provider had no recorded complaints in the twelve months prior to the inspection.

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

Inadequate: There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

At the last inspection completed in February 2019 we found the provider to be rated as 'inadequate' for this key question. They were not meeting the requirements of the law in relation to the governance systems and quality assurance of the service. At this inspection we found the provider had failed to make improvements and continued to fail to meet the requirements of the law.

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

- The provider had failed to ensure concerns addressed at prior inspections spanning a number of years were addressed and resolved. The provider had failed to ensure they had systems in place to make sure required improvements were made, sustained and built upon to improve the safety of the service and quality of life of people living there.
- The provider had failed to ensure the management team had a good understanding of the required standards within the service. They had failed to ensure they had the skills and competency required to recognise when regulations were not being met. For example; the manager had stated that improvements required to the application of the Mental Capacity Act 2005 (MCA) had been fully addressed although we found this not to be the case and people's rights were not being upheld.
- The provider had failed to ensure their quality assurance systems were effective in identifying risk and areas of improvement required within the service. They had not identified issues we found across the service; including but not limited to the concerns with medication, record keeping, weight loss, risk management, the management of challenging behaviour, falls, staff deployment, staff competency and ensuring people were treated with dignity and respect.
- The provider had failed to ensure that communication systems were in place to ensure staff understood key risks to people and their individual needs. Staff we spoke with had inconsistent views around who had 'do not resuscitate' directives in place, who was losing weight, who was at risk of falls, who demonstrated behaviours that could challenge and which service users had diabetes. As a result, staff were not providing consistent, effective care that ensured the needs of individuals were met and the risk to both themselves and others was mitigated against.
- The provider had failed to develop an effective system that enabled them to accurately assess the number of staff required to support people safely and in a person-centred way. There was no system in place at the time of the inspection and we identified concerns about the availability of staff with clinical knowledge, the volume of agency staff being used and the effective deployment of staff across the building. The provider had failed to identify these concerns.
- The provider had failed to develop effective systems to assess staff competency in their roles and to identify areas for training and development that may be required. We saw extensive concerns with the skills

and competency of care staff and this had not been identified by the provider.
•□The provider had failed to ensure there was a culture of continuous learning in the service. They had been rated as requires improvement since ratings were reintroduced in 2014 and had failed in this four year period to use past concerns in a positive way to learn and make improvements moving forward.
•□We found a lack of analysis of incidents including accidents and incidents had resulted in the provider not identifying areas in which further investigation or improvement was required. For example; we found from accident records that most accidents were arising while night staff were on shift. The provider had not identified this trend, had not completed any further investigation, taken any corrective action and had not used the learning to drive improvements and minimise risk to people living in the service.
•□The provider's failure to ensure that all accidents and incidents were reported accurately meant that any monitoring systems were ineffective. For example; the most recent accident record for one service user was 07 April 2019, yet their daily records stated they had fallen on 25 April 2019.

The providers failure to ensure that robust quality assurance and governance processes were in place were a continuing breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance

•□The provider had failed to ensure that all statutory notifications were submitted to CQC as required by law. A statutory notification is required to inform CQC about significant incidents such as safeguarding concerns, serious injury or incidents involving the police. We identified incidents involving safeguarding concerns and also police contact that had not been notified to the commission.

The providers failure to ensure that the required statutory notifications were sent was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 Notification of other incidents

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
•□We found the provider had failed to develop effective systems to ensure people were fully involved in the development of the service in line with their abilities and capacity. While surveys had been issued, most people at the service did not have the mental capacity or physical ability to complete the surveys. The manager was not aware of the Accessible Information Standard and had not produced surveys in an accessible format.
•□We saw reviews of people's care were recorded in care plans and all feedback recorded was positive.
•□Most staff gave positive feedback about the manager and said they felt involved in the service. Some staff however felt this was not the case and said they were just expected to 'get on with the job'.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility;
•□Some people told us they felt the manager was very open and approachable. One person told us, "I know the manager, she's very approachable and very nice and I can knock on her door".
•□We found both the provider and the manager were receptive to feedback given to them during the inspection but failed to recognise their own responsibilities and take full accountability for the issues within the service.
•□The provider and manager were not proactively encouraging people to share concerns with them and to seek out areas of improvement required in order to make improvements. They had not reviewed the resources required in order to drive the major improvements that we identified as being required and had not taken any proactive action to ensure people were receiving a high quality of care and support.

Working in partnership with others

- We found the provider had not developed links with the service and the wider local community.
- The provider had also not developed positive working relationships with other agencies and healthcare professionals which enabled people to receive support promptly and increased their quality of life.