QH Greenhill Limited

Greenhill Residential Care Home

Inspection report

Priscott Way
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Greenhill Residential Care Home is a residential care home providing personal care to 33 people aged 65 and over at the time of the inspection. The service can support up to 36 people. Accommodation is over two floors and each person has a spacious 'flat' which consists of a small hallway, a bathroom and a bedroom with a kitchenette area. There is a large lounge and dining area on the ground floor and a second quieter communal room.

People's experience of using this service and what we found
People were not protected from the spread of infection. Staff were not using personal protective equipment (PPE) in line with either UK Government guidance or the providers own policies. On the first day of our inspection we observed numerous members of staff either not wearing a mask at all, wearing one incorrectly or wearing the wrong type of mask. No action had been taken to encourage good infection control practice around the building and staff had not completed any Covid-19 specific training. Some improvements had been made by day two of our inspection.

People at risk of choking were not always supported safely or in line with the advice of external professionals. There were not enough staff to meet people's needs and a high level of staff sickness exacerbated this. Peoples medicines were generally managed well, and risk to people and risks associated with equipment and premises were regularly reviewed. We recommended that records relating to PRN medicines be reviewed and sufficient information be recorded to enable staff to identify when it is appropriate to use them. Staff told us they knew how to recognise and report safeguarding concerns.

New staff did not receive a thorough induction and most staff had not completed training required to ensure they had the required knowledge and skills. One staff member told us "I can't remember the last time we had any training." Very few staff had completed first aid training and there were often no first aid or fire trained staff on duty.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the systems in the service did not support this practice. There was confusion and misunderstanding about their responsibilities under the Mental Capacity Act; applications to deprive four people of their liberty had been made without first assessing their capacity to make the decision for themselves.

Advice from healthcare professionals was not always sought in a timely way. People were not encouraged to be involved in the design and decoration of the service; however, some improvements had been made including décor to make peoples flat doors look like the front door to a house, 'cloud' feature lights and redecoration.

People were not always treated with dignity or well supported. People were not being regularly assisted with

oral hygiene and staff confirmed to us that this was an ongoing problem. One senior member of staff told us that care was "very basic." Staff used some institutionalised language and people were drinking out of plastic cups with no rational as to why. Staff were working hard to meet people's needs as best they could, and we observed some kind interactions. People seemed comfortable when interacting with staff. One person told us "the staff are wonderful, they really are."

People did not always have care plans in place. Since the last inspection, an electronic care planning system had been introduced. We found two people had electronic care plans in place with very minimal information, and a further six people had no care plans at all. This meant staff had little or no guidance as to how to meet their needs or what their personal preferences were. People who had lived at the service for more than 12 months had paper care plans in place, and whilst they were of good quality, staff told us they did not have time to read them.

At our last inspection we recommended that there be more robust arrangements for meeting people's leisure and social needs on a more regular basis to ensure everyone's particular needs were known and met. Improvements had not been made. We observed people in the communal lounge engaging with and enjoying an activity, however no meaningful activity was provided for people remaining in their rooms. Records showed long periods of time where some people had no social interaction.

At our last inspection we recommended that the provider ensured their oversight and governance was more robust to ensure the Registered Manager and staff were more supported and clearer about their roles. Improvements had not been made. The Registered Manager was not clear about their responsibility to follow UK Government guidance in relation to infection control and the Covid-19 pandemic. They had not implemented the guidance, nor followed the providers own policies. The provider had failed to make any checks. Whilst there were quality assurance systems in place, they did not always identify where improvements were needed, or where they did identify it action was not always taken to resolve it.

Staff told us the registered manager was supportive and worked with them to provide care when staffing levels were low, however, it was clear that they did not feel well supported by the provider. Staff told us they were upset to have not had any thanks from the provider throughout the Covid-19 outbreak. The Registered Manager worked in isolation, had not engaged in any local support networks and without guidance from the provider had found it difficult to keep up to date with current guidance and best practice.

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 14 June 2018). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
We undertook this focussed inspection to check they had followed their action plan and to confirm they now met legal requirements.

On day one of our inspection we identified significant concerns in relation to the management of infection control, the use of personal protective equipment (PPE) and how risks for people with impaired swallow were managed. Because of these concerns we expanded the scope of our inspection to a full comprehensive.

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.

The overall rating for the service has changed from Requires Improvement to Inadequate. This is based on the findings at this inspection.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to: safe care and treatment; person centred care; dignity and respect; need for consent; staffing and good governance at this inspection.

We also made two recommendations to improve practice in relation to the administration of 'as required' medicines and supporting people to make choices at mealtimes.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe.	**Inadequate**
Is the service effective? The service was not effective.	**Inadequate**
Is the service caring? The service was not caring.	**Inadequate**
Is the service responsive? The service was not responsive.	**Inadequate**
Is the service well-led? The service was not well led.	**Inadequate**

Greenhill Residential Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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 conducted by three inspectors.

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

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

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We used the

information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection-
During the first day of inspection we spoke with the registered manger and four members of staff. We reviewed four people's care plans, two people's oral healthcare records, incidents, accident and complaints records, records relating to Deprivation of Liberty applications, cleaning schedules and records relating to food and drink. We spoke with three people and observed lunch. We spoke with one visiting professional.

During our second site visit we spoke with the registered manager, the deputy manager and eight members of staff including senior care staff, care staff, domestic staff and the cook. We reviewed eight people's medication records and eight people's care plans. We looked at records relating to recruitment and supervision of staff, quality assurance and maintenance. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

After the inspection –
We continued to review records sent to us and sought clarification where needed. These included staff rotas, policies and procedures, training records and staff meeting minutes. We spoke with four relatives. We sought feedback from four professionals who work with the service and received feedback from two.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Preventing and controlling infection

- People were not protected from the risk of infection.
- Staff were not using PPE in line with UK Government guidance. On the first day of our inspection we observed numerous members of staff either not wearing a mask at all, wearing one incorrectly or wearing the wrong type of mask. Staff continuously touched their masks and re-used the same mask after a break.
- Staff did not use gloves and aprons when providing all close contact care, including when assisting people to eat and drink and administering medicines. Staff did not perform any hand hygiene after assisting one person and before assisting another.
- There was no hand sanitizer available throughout the building. There were no PPE stations to enable staff to perform hand hygiene or put PPE on before entering a person's flat, including the flat of one person who was isolating after admission to the home. PPE was stored on the top of people's toilets which was a cross contamination risk. Staff did not dispose of PPE safely, leaving used PPE in open bins.
- There was no record of any deep cleaning taking place. A member of domestic staff told us they had not received training about Covid-19 or enhanced cleaning methods. High touch points were often only cleaned once per day and cleaning records showed several days where no cleaning was done at all.
- Of 59 staff members, 30 had not completed any form of infection control training. No specific Covid-19 training had been completed by any staff, despite this having been offered by the Local Authority.
- People were not encouraged to socially distance and no changes had been made to the physical environment to minimise the risk of the spread of infection.
- The providers policies had not been implemented. For example, no contingency plans had been created to implement in the event of an outbreak of Covid-19.

The service did not assess or take action to prevent the risk of the spread of infections which exposed people to the risk of harm. This is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- We raised our concerns with the registered manager during our first day of inspection. We also wrote to the provider to inform them of our concerns. They sent us an action plan which assured us the immediate risks would be addressed. We checked the progress of these actions during our second site visit and by the end of the day were satisfied that the most serious concerns had been addressed.
- We noted improvement in staffs use of PPE on day two. All staff were now wearing the correct type of mask.

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

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

We have also signposted the provider to resources to develop their approach. We asked the provider to ensure they reviewed current Government guidance in relation to visiting and to ensure people were supported to receive visits in line with this.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
●Risks to people were not always well managed.
●Some people had been assessed as needing a modified diet and thickened fluids. Information regarding this was incorrectly recorded. For example, one person had been assessed as requiring a level 6 'soft and bite sized' diet and this was recorded in their care plan, however, their 'health needs care plan' stated 'stage 4 food' and documents being used by the kitchen team stated, 'soft diet.'
●This person was assessed by the speech and language team on 14 May 2021 who recommended a soft and bite sized diet but recognised they would sometimes choose to eat higher risk foods. Staff were advised to supervise them closely when they did this. This person had a choking incident on 16 May 2021 and records state that his food had not been prepared in bite sized pieces. Records show they routinely ate their tea alone in their bedroom with no supervision, including when eating higher risk foods.
●Only three out of 59 staff had completed first aid training so there was often no first aid trained staff in the building, should someone choke. The cook confirmed they had not had training in relation to modified diets in the past three years and was not clear on what the different 'levels' meant.
●We raised safeguarding concerns in relation to the individuals at risk.

People were at risk of choking and these risks had not been mitigated. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

●Risks relating to fire had been assessed and evacuation equipment was stored in appropriate places. Periodic fire drills had taken place; however, the alarm system was not always tested on a weekly basis.
●Premises risk assessments were in place and maintenance of equipment completed by an outside contractor.
●Risk to people, for example fall's and pressure area damage, were assessed and regularly reviewed.

Staffing and recruitment
●There were not enough staff to meet people's needs.
●The provider used a dependency tool to determine staffing levels, however, the registered manager and senior staff told us that the planned staffing levels were not always sufficient because of the high level of people's needs. The provider did not allow the use of agency staff to cover in the case of sickness.
●In the eight weeks prior to the inspection staff rotas showed staffing levels fell below the planned levels on 30 occasions, 24 of which were night shifts. On other occasions, there were sometimes four or five additional staff on duty. One staff member told us the rota was planned around individual staff member requests rather than people's needs.
●Staff sickness was having a significant impact on the number of staff available to work. During the eight weeks prior to inspection 26 staff members called in sick which affected a total of 73 shifts. A senior member of staff told us that when staff call in sick they "generally have to work without," meaning they had less staff than were needed on duty.
●A senior member of staff told us new staff often leave because "it's so hard." Another staff member told us that there was a "huge shortage of staff, five people have left in the past few weeks, in the afternoon there are sometimes only four staff." The registered manager told us the dependency tool used indicated six care staff were required, however, they felt that was not always sufficient. They had raised this with the provider

previously.
●There were not always enough domestic staff on duty. One staff member told us there should be two domestic staff on duty to enable them to complete the required tasks, but there was often only one.
●Senior staff told us they did not have time to perform any checks to ensure care staff had met people's needs in line with their care plan. Staff did not have time to spend with people other than for care tasks so were unable to meet people's social and leisure needs.

There were not sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet people's needs which exposed people to the risk of harm. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Using medicines safely
●Records to guide staff when administering 'as required' (PRN) medicines were poor. For example, two people were on medication intended to assist with insomnia and anxiety. There were no instructions about how to ascertain when these medicines were to be offered, what behaviours may present for people and what methods to use before resorting to medicine. On the medicine administration records we saw that both medicines had been used multiple times, however no rational as to why it was used, or what the effect of the medicine was, was recorded.

We recommended that records relating to PRN medicines be reviewed and sufficient information be recorded to enable staff to identify when it is appropriate to use them.

●People's regular medicines were well managed, and the service had a good relationship with their local GP.
●Anticipatory medicines for people at end of life were ordered appropriately and in stock.

Systems and processes to safeguard people from the risk of abuse
●The service had made some alerts to the local authority, however, they did not always recognise when an alert should be made.
●Whilst a significant number of staff had yet to complete safeguarding training, staff told us they knew how to recognise signs of abuse and were confident in reporting any concerns.

Inadequate

Is the service effective?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate.

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

At our last inspection the provider had failed to ensure staff had received appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. This was a breach of Regulation 18 (Staffing) 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 18.

Staff support: induction, training, skills and experience

- New staff did not receive a thorough induction and they didn't always have the opportunity to shadow experienced staff. One senior staff member told us that new staff were "shadowing staff who don't know what they're doing", a carer told us "a lot of the staff aren't trained to do their job properly."
- The training matrix identified significant gaps and large numbers of staff had not completed any training in essential subjects. For example, 39 of the 59 staff had not completed any safeguarding training, 53 staff had not completed practical moving and handling training and there were five senior members of staff who had not completed recent medication training, despite the fact they regularly administered medication.
- Very few staff had completed any training in areas which would support the development of the skills needed to meet people's individual needs, such as dementia care and understanding challenging behaviours.
- One senior staff member told us they "can't remember the last time we had any training." Staff were allocated online training, but senior staff found it hard to find time to release them to complete it.
- Supervisions had just begun to take place, however there had been a gap of 12 months where no supervisions or appraisals had taken place. Actions identified in those supervisions had not been followed up.

There were not sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet people's needs which exposed people to the risk of harm. This was a continued breach of Regulation 18 (Staffing) 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 Act requires that, as far as possible,

people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA.

●The requirements of the MCA were not consistently met.
●There had been confusion and misunderstanding about when to make an application to deprive people of their liberty. Applications had been made to deprive four people of their liberty without first assessing if they had the capacity to make the decision themselves.
●Where people had fluctuating capacity, assessment of their capacity to make specific decisions did not always take place. For example, one person with fluctuating capacity declined to have a flu vaccination, however no assessment was made to ensure they fully understood the potential consequences of that decision.
●Decisions made in people's best interests were not documented.

Systems and processes were not in place to ensure care and treatment was only provided with the consent of the relevant person. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Supporting people to eat and drink enough to maintain a balanced diet
●People were not routinely offered a choice of cooked meals. There were no menus to choose from and only one main cooked meal offered each day.
●Alternatives such as a sandwich or soup were available, and people were asked to make their choice the previous afternoon.
●The cook knew peoples likes and dislikes and was happy to provide a variety of different meals, however, people who were unable to express their needs were not supported to make a choice.

We recommended the provider consider ways of giving people more choices around their menu.

●Care staff had access to the kitchen and to a small fridge so they were able to make sandwiches or prepare eggs, for example, if people were hungry outside of the kitchen staffs working hours.
●One person chose not to eat pork, this was detailed clearly in their care plan, staff were aware of this and eating and drinking records confirmed they had been given alternative meals on days pork was served.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
●Care was not always provided in line with standards, guidance and the law.
●People's capacity was not always assessed before decisions were made on their behalf.
●Government guidance in relation to the management of Covid-19 had not been understood or implemented.
●A pre-assessment was completed prior to people moving to the service to ensure they were able to meet people's needs.

●Specialist equipment was sought where required.

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

●Advice was not always sought from other agencies in a timely way. One external professional told us that a family member had requested the service contact their loved one's GP for a specific health issue. This had still not been done six days later; the professional contacted the GP themselves to resolve the issue.

●Another person had experienced recent weight loss, and we saw that a prompt referral to their GP had been made.

●District Nurses visited the home regularly and the service had an ongoing working arrangement to provide Intermediate Care to people needing a short respite stay between a hospital admission and returning home. A member of the intermediate staff team told us they had "no concerns, any issues they contact us."

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

●People's needs and preferences were not always taken into account.

●The building is a circular building with a secure garden in the centre. It had not been maintained and was overgrown with uneven surfaces. This meant that people had to be accompanied to be able to use the outside space safely and were not able to use it independently.

●People were not consulted in relation to changes to the design and decoration nor were their needs fully considered. For example, the provider had recently purchased some new chairs, however, they were not easily cleanable and neither people nor staff had been consulted.

●People were able to have their own belongings in their flats and personalise them as they wished. One person had created an 'art studio' in the corner of their room. They told us that it gave them a sense of purpose and "was a god send."

●Improvements had been made to the design of the service. This included décor to make peoples flat doors look like the front door to a house, 'cloud' feature lights and redecoration.

Inadequate

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate.

This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

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

- People were not always treated with dignity or well supported.
- People were not being assisted to brush their teeth. We saw people's toothbrushes were dry and hard, people's mouths were sticky and dirty, and records confirmed there were large gaps in people's oral healthcare records. A care assistant told us "oral care is terrible", a senior member of care staff told us this was a "bug bear" and that care staff sometimes recorded that they had brushed people's teeth when they had not. A visiting professional told us a person's teeth "were not clean, food or plaque was visible between their teeth. Care records showed dental care was provided at 08:14 this am but the debris predates that time."
- We observed people in the communal area with food dried around their mouths. One person was still wearing a clothes protector from breakfast time at 11.30am, we prompted staff to remove it.
- Senior staff and the Registered Manager told us that sometimes people arrived in the communal area without having their hair brushed, their teeth brushed and with untidy clothes. One senior member of staff told us that care was "very basic." One staff member told us that they sometimes come into work in the morning and find people "in the same clothes they were in the day before."
- We saw multiple packets of 'Dry wipes' in peoples bedrooms. Staff told us they were being used to wash people with, because there were not enough flannels.
- Staff did not have time to meet people's emotional needs. We observed people in the lounge unattended for over 30 minutes, people were becoming visibly anxious. A member of care staff told us some staff didn't "know how to talk to residents, they talk to each other over them, not to the resident."
- Staff used institutionalised language and referred to people as 'singles' or 'doubles' according to how many staff they needed to assist them. People were using plastic cups without any rational as to why this was necessary.
- Notices within people's hallways displayed their 'pad allocation' in large typeface and could be seen by anybody entering the room.

People were not treated with dignity and respect. This was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- Staff were working hard to meet people's needs as best they could, with limited resources.

●We observed some kind interactions, and people seemed comfortable when interacting with staff. One person told us "the staff are wonderful, they really are."
●We received positive feedback from some family members. One said the staff were "absolutely wonderful, very kind and caring." Another said the service was "absolutely fantastic."

Supporting people to express their views and be involved in making decisions about their care
●People were not invited to be part of decisions relating to their care. We asked one person, who had lived at the service since 31 March 2021 if they had a care plan, they did not know. When we checked, there was no care plan in place.
●Family members told us they felt involved in their loved one's care, one said they "tell me right away if there are any problems."

Inadequate

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate.

This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

At our last inspection we recommended that the registered manager ensured that all staff consistently have the information they need so person centred care delivery could be monitored in a more robust way. Improvements had not been made.

●People did not always have care plans in place. Since the last inspection, an electronic care planning system had been introduced. Once this was in place the intention was that people should have had care plans created on this system, however, this did not happen. We found two people had electronic care plans in place with very minimal information, and a further six people had no care plans at all. This meant staff had little or no guidance as to how to meet their needs or what their personal preferences were.
●The registered manager had identified that these care plans had not been created when auditing care plans however no progress had been made. The registered manager and deputy manager acknowledged that staff required more training and that staffing levels had impacted upon this.
●Because staff had not been fully trained and were not confident in completing electronic care plans, information that had been recorded did not always make sense. For example, one person's mobility and motor control care plan stated, "I am independent but use a walking aid or wheelchair; a walking aid or wheelchair to move from place to place and have use of an aid to stand up." This was not person centred and did not explain to staff how to help the person safely mobilise.
●People who had lived at the service for more than 12 months had paper care plans in place, and whilst they were of good quality, staff told us they did not have time to read them. Two staff told us they only looked at the electronic system.

People's care did not meet their individual needs and preferences. This was a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

●Care plans that had been completed prior to the introduction of the electronic system contained detailed and person-centred information. This included information about what made a day 'good' or 'bad' for a person and how staff could help them have a good day.

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

At our last inspection we recommended that there be more robust arrangements for meeting people's leisure and social needs on a more regular basis to ensure everyone's particular needs were known and met. Improvements had not been made.

●No changes to the activity provision had been made since our last inspection. Whilst two dedicated staff worked over six days providing a varied activity programme, there was no audit of how effective they were or individualised records.
●Records showed long periods of time where some people had no social interaction. One person had no social interaction recorded for 21 out of 28 days, another person had no social activity recorded for 20 days. Staff told us they could not always record social interaction as there were not enough electronic devices to go around but acknowledged they did not have time to spend quality time engaging with people.
●We observed people alone in their rooms with little stimulation. Staff told us there was no system in place to ensure people were regularly checked.
●We observed some people in the communal lounge engaging with and enjoying an activity, however no meaningful activity was provided for people remaining in their rooms. Activity staff were busy and attempted to spend time with people, but their time was limited.
●Care staff were not involved in activities, only care tasks. One senior staff member told us "carers don't really get a lot of time to spend with people. We encourage them to, but they don't get the time."

People's care did not meet their individual needs and preferences. This was a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

●Some people were supported to take part in activities that were meaningful to them. For example, one person enjoyed painting and told us an activities member of staff would take him for walks, take photographs of the landscape and then print them out, which they then enjoyed using to paint from.

Improving care quality in response to complaints or concerns
●Staff and family members told us they felt comfortable raising concerns, however, they told us little changed as a result of these.
●One family member told us they had requested an external professional be contacted for their relative on a number of occasions, but it had not happened.
●A senior member of staff told us they had previously raised concerns but "nothing gets done."

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
●No efforts had been made to improve communication for people who may have found alternative methods easier to understand.
●People living with dementia were asked verbally, a day in advance, what they would like to eat for lunch the next day. Other methods of communication, such as pictures, and the conversation taking place in a more timelier way, such as at the time of the meal, had not been considered or implemented.

End of life care and support
●Staff did not have specific training in meeting people's needs at the end of their life.
●Care plans created before the online system was introduced contained some very person centred and detailed information about people's wishes at the end of their life. One person's plan stated how important

their religion was to them and included words they wished to have read to them as they passed away.
●People's family members had thanked staff for their supportive care at the end of their loved one's life. One person said "Thank you for all the care you gave to my dear mum as she passed away."

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At our last inspection we recommended that the provider ensured their oversight and governance was more robust to ensure the registered manager and staff were more supported and clearer about their roles. Improvements had not been made.

- The registered manager was not clear about their responsibility to follow UK Government guidance in relation to infection control and the Covid-19 pandemic. They had not implemented the guidance, nor followed the providers own policies. The provider had failed to make any checks, and, when they were advised by an external auditing company that improvements were required, did not act on their advice.
- One staff member told us they challenged poor IPC practice several months ago but were told "it's only guidance." When we asked senior staff if they had seen the Government guidance, they told us they had "not been privy to that side of things." Senior staff were not given the information they needed to ensure care was delivered safely.
- Senior staff were not given time to undertake basic checks to ensure people were receiving good quality care. Where staff and management were aware that people were not receiving good quality care little action was taken. For example, it was widely accepted by the staff we spoke to that oral healthcare and personal care by newer staff was of a very poor standard.
- There had been no supervisions or appraisals for around 12 months. Performance issues that had been identified prior to this time had not been addressed including cleaning and infection control.
- The provider did not visit the service on any regular basis and did not appear to have any oversight or make any checks of the quality of care delivered. One staff member told us that the providers "run it from a distance, they don't show their faces" and that the provider did not speak to staff when they did visit.
- The registered manager and three senior staff members told us that staffing levels and budget were controlled by the provider and that they had raised concerns that the dependency tool used did not fully recognise people's levels of need. One senior staff member told us that the provider doesn't "see when people need that one to one time." For example, one person was mobile and visibly anxious. Staff were only able to stop briefly to check they were safe and the person spent the day walking around the home with little interaction.

●Because there were not always enough staff to meet people's needs it was at times impossible for staff to deliver person centred care, and people were receiving assistance at times that suited the staff. One staff member told us "we'll start feeding people earlier to have enough time. Some people have to go to the dining room at 4.30pm so they can fit in."
●There were systems and process in place to audit and analyse care records, however, action was not always taken to rectify issues identified. For example, the Registered Manager was aware that several people did not have care plans in place but did not take any action to ensure staff knew how to meet their needs.

Systems and processes were not operated effectively to ensure the service was Well-Led. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

●Staff told us that the registered manager would provide care themselves when there were not enough staff on duty, one staff member told us how much they enjoyed working with them.
●Family members knew who the management and senior staff were, and on the whole provided positive feedback. One family member told us "the seniors are lovely."

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; Working in partnership with others; Continuous learning and improving care
●The registered manager did not keep themselves up to date with current guidance or best practice. They did not engage in any local managers groups, other managers within the providers group of homes or the Local Authority run Providers Engagement Network.
●Whilst electronic systems in place made it very straightforward for senior staff to have good oversight of the quality of care provided, no action was taken to identify where improvement was needed or learn from where things went wrong.
●Referrals to external professionals were not always made at appropriate times and the advice given was not always followed. For example, care records showed one person, who should have been supervised, regularly ate foods that posed a choking risk alone and unsupervised. When we asked the registered and deputy managers about this, they told us they believed staff were following the guidance and were shocked and upset to hear they were not.
●The service had previously worked with the Local Authority to improve the quality of care. Where they identified something had gone wrong, they notified both CQC and the Local Authority.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
●People, their families and staff were not engaged or involved in the development or day to day running of the service.
●Staff did not feel listened to or appreciated. One told us they had raised concerns but "nothing gets done." Four staff we spoke to told us they were upset that they had not received any thanks from the provider for their hard work during the pandemic.
●Periodic staff meetings were held, however, the minutes of these indicate they were a forum to communicate information from management to staff. No resident or family meetings had been held.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care did not meet their individual needs and preferences.

The enforcement action we took:

We imposed a condition on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not treated with dignity and respect.

The enforcement action we took:

We imposed a condition on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Systems and processes were not in place to ensure care and treatment was only provided with the consent of the relevant person.

The enforcement action we took:

We imposed a condition on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service did not assess or take action to prevent the risk of the spread of infections which exposed people to the risk of harm. People were at risk of choking and these risks had not been mitigated.

The enforcement action we took:

We imposed a condition on the providers registration.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not operated effectively to ensure the service was Well-Led.

The enforcement action we took:

We imposed a condition on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet people's needs which exposed people to the risk of harm.

The enforcement action we took:

We imposed a condition on the providers registration.