St Marks Care Home Limited

St Marks Residential Care Home

Inspection report

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

Summary of findings

Overall summary

About the service
St Marks is a residential care home providing accommodation and personal care for up to 17 people aged 65 and over, in one adapted building. There were 13 people living in the service at the time of the inspection, who were vulnerable due to their age and frailty, including varying levels of dementia related needs.

People's experience of using this service and what we found
The service was not well led. The provider had not done what they told us they were going to do to make and sustain improvement following the last inspection. There continued to be a failure to independently recognise and identify significant failings impacting on the quality and safety of service provision. Lessons had not been learned to minimise risk and drive improvement.

Thorough risk assessments were not carried out routinely to identify and mitigate risks in relation to people's healthcare and support needs; safety concerns were not recognised, and practice placed people at risk of harm.

Management and staff were not following Government guidance and best practice infection prevention and control (IPC) guidance. Measures to limit the risk of cross infection continued to be neglected compromising people's safety and welfare. Areas of the home were still not clean, and the provider was failing to have effective and additional cleaning schedules in place for frequently touched areas and deep cleaning.

Whilst some areas of the home environment had improved the appearance of other areas remained poor.

There were not enough staff to provide adequate supervision, nutritional support, infection prevention and control, stimulation and meaningful activity. This had a direct impact on people's safety and welfare.

We continued to have concerns about the skills, experience and knowledge of staff. Improvements were needed in staff's understanding of dementia care to enable them to support people in providing care that was effective and person centred. This included staff's knowledge in managing high levels of anxiety, dysphagia and supporting people to have access to meaningful stimulus, tailored to their level of dementia/needs.

The culture within the home did not promote a holistic approach to people's care that ensured their physical, mental and emotional needs were being met. 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.

Staff were not supporting people in a planned, personalised and consistent way. There were lots of inconsistencies in how well people's care needs and preferences were recorded which meant there was a risk that people may not receive care in line with their needs and preferences.

Immediately following this inspection, we made safeguarding alerts to the local authority. The local authority safeguarding, and quality improvement teams continue to monitor the service through management support and regular visits to ensure the safety of people living at the service.

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

Rating at last inspection and update
The last rating for this service was inadequate (published 4 August 2021). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

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

We looked at infection prevention and control measures under the Safe key question. We look at this in all care 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. This included checking the provider was meeting COVID-19 vaccination requirements.
The overall rating for the service remains inadequate based on the findings of this inspection.
You can see what action we have asked the provider to take at the end of this full report.

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

We have identified continued breaches in relation to Regulation 9, 12, 13, 17, 18 and a new breach of Regulation 14 at this inspection.

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 continue to monitor information we receive about the service. The local authority safeguarding, and quality improvement teams continue to monitor the service through management support and visits to ensure the safety and welfare of people living at the service.

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

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

For adult social care services, the maximum time for being in special measures will usually be no more than

12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

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 always caring.

Details are in our caring findings below.

Requires Improvement

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

St Marks 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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This included checking the provider was meeting COVID-19 vaccination requirements. 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 carried out by two inspectors

Service and service type
St Marks is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. St Marks is a care home without nursing care. 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 to manage the service. The registered manager was also the sole director of the company which owned the service. This means 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

The inspection activity started on 7 March 2022 and finished on 15 March 2022. The inspection was unannounced on 7 and 10 March 2022, we also carried out an announced visit on 8 March 2022.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with eight members of staff including the registered manager, newly appointed manager, the deputy manager, three care staff, the cleaner and the activity co-ordinator. We spoke to four people. We reviewed a range of documents and records. These included people's care, support and medicine records, policies and procedures, staff personnel records relating to recruitment, training, development and supervision, and records relating to the running of the service.

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 raised urgent concerns with the provider. We raised five individual safeguarding concerns with the local authority safeguarding team for investigation.

We spoke with the relative of three people living at the service.
We requested further information from the provider.

Inadequate

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management

At our last two inspections the provider had failed to robustly assess the risks relating to people's health, safety and welfare. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment.

This inspection found

- People continued to be at risk because management and staff were not independently recognising and identifying risk and taking effective action to protect people from harm.
- People with dementia are more susceptible to swallowing difficulties (known as dysphagia) resulting in an increased risk of choking. There were no systems in place to guide staff about people known to be at risk of choking.
- We observed a mealtime; three people coughed continually whilst eating and drinking. One person, at high risk of choking was left to eat unsupervised. They stopped eating due to the distress the coughing caused. This went unnoticed by staff. A staff member told us the person always coughed when eating and drinking.
- Another person, at high risk of choking was prescribed a level four food consistency to reduce their risk of choking. We observed they were eating foodstuffs of the wrong consistency, increasing their risk of choking.
- Some people were left fully clothed in bed throughout the day, with no access to drinks, and were at risk of overheating, dehydration and skin damage. One person at high risk of skin breakdown was left with their skirt rolled up and ruffled beneath them. This increased their risk of skin breakdown from uneven pressure. A health professional told us they had previously pointed out this risk to staff.
- Personal emergency evacuation plans (PEEPS) had not been reviewed and revised since our last inspection. On this occasion we found PEEPS did not reflect the use of emollients which can increase the risk of fire and serious harm.

Preventing and controlling infection

- The environment did not support good infection control and areas of the home continued to be unclean and unhygienic.
- Some mattresses viewed were dirty and stained; there was no audit in place to check the quality and cleanliness of mattresses.
- Systems for cleaning and disinfection of items, such as commodes, were not being carried out in line with nationally recognised guidance, such as Department of Health Code of Practice on Prevention and Control of Infections and related guidance.

● The service did not have sluice facilities or equivalent for the emptying, cleaning and disinfecting of commodes; there was no cleaning schedule to reduce the risk of cross infection; and we saw dirty commodes in bedrooms.
● Despite continued COVID-19 exposures cleaning had not been formally reviewed. There were no enhanced or more frequent cleaning schedules in place to minimise risks to people and staff.
● Infection control policies were not service specific and did not reflect accurately the environment or staffing structure. For example, the policy dated March 2022 stated, 'The head housekeeper is responsible for ensuring cleanliness levels are maintained with the team of housekeepers.' The service employed only one part time cleaner.
● The systems for provision and disposal of relevant personal protection equipment (PPE) were poor; not all masks and gloves were kept in enclosed wipeable dispensers increasing the risk of cross infection.
● Although management and staff had received training in infection control and the use of PPE, they were not always following safe practice, placing people at risk. This included not covering their nostrils with face masks, and poor hand hygiene.
● The provider had not made sure infection outbreaks could be effectively prevented or managed.
● The service contingency plan was not service specific. It did not provide planned and written guidance for staff to know how to immediately put in place full infection control measures to care for people with symptoms and minimise spread of infection. For example, the planning stage had not been followed to ensure there were enough foot operated waste bins in the service.
● There was no effective system in place for the safe management of people self-isolating. We had to advise the provider to check and implement government guidance when a person returned from hospital. Their room had not been prepared for their return with regards to provision of PPE and waste management; the foot operated waste bin was taken from the laundry and put into the bedroom.

Systems were either not in place or robust enough to manage safety effectively. This included management of the risk of choking, health and safety, infection prevention and control and COVID-19. This placed people at risk of harm. This was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We referred the provider to the local infection prevention and control team for a full review and to support them to develop their approach.

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was accessing testing for people using the service and staff.
● The provider had addressed our concerns regarding the laundry. New impermeable wall coverings and flooring had been installed that allowed effective cleaning to minimise risk of contamination and infection. The area was clean and free from fluff and dust.

Visiting in care homes
● The provider used a flexible booking system and testing facility for family members to visit safely.

Staffing and recruitment
At our last inspection the provider failed to ensure enough suitably qualified, competent, skilled and experienced staff were deployed to meet people's needs, at all times, and ensure safe, good quality care. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This inspection found very little improvement had been made and the provider was still in breach of

regulation 18.

● The provider did not have a clear overview of the complexity of people's current needs and levels of dependency.
● The dependency tool used to inform the providers decision on staffing numbers did not take account of people's personalised needs and risk including social, emotional or dementia related needs. It therefore did not reflect dependency levels accurately.
● The provider did not have a contingency plan in place to address unforeseen staff absences to ensure there were always enough and available staff. The provider had not addressed the long-term absence of the cook. A member of the care staff team was allocated daily to prepare and cook lunch, which reduced the number of staff delivering care and support.
● There was not enough staff to support people to eat well and safely or have flexible access to the community.
● Staff continued to demonstrate a lack of understanding or competence in how to effectively communicate, interact, engage with or support people living with dementia.
● The domestic cover did not meet the cleaning requirements of the home. The cleaner worked four hours a day Monday to Friday.
● There were less staff at weekends, with no management or leadership. Care staff covered other non-care related duties.

This evidence demonstrates a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

● The provider was not following safe recruitment procedures and failed to assure themselves newly recruited staff were of good character and sufficiently skilled, competent and experienced for the role.
● For the most recently recruited senior positions the provider had not always obtained the applicants full employment history, or validated previous employment working with vulnerable adults.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● The service continued to put people's safety and welfare at risk. There was not a culture of learning. Lessons had not been learned and used to improve the service and limit risks to people.
● Management and staff did not understand their responsibilities to report and record safety incidents, concerns and near misses. For example, incidents such as a person slipping over or found on the floor were not reported as an incident, in line with their policy.
● Information and outcomes from the local authority safeguarding investigations were not being used to drive continuous improvement and manage future performance.
● A previous recommendation by the local authority safeguarding team was to improve accuracy of individual care records. We found not all staff were keeping accurate records for people's food and fluid intake. We raised this with the registered manager. The following day a member of the safeguarding team found the same.

Using medicines safely
● Medication audits were carried out monthly, one medication administration record is reviewed as part of the audit however this would not provide an effective overview of medicine management.
● The audit lacked any identified areas for improvement; where criteria has not been met the records do not show how the issues had been addressed, when or by who.
● A person's family member told us they were kept updated about any changes to their relative's medicines, including why they had been prescribed by the GP.

● The GP had prescribed 'anticipatory' medication for a person at end of life in readiness for community nurses to administer to control pain when required.

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.

Our inspection on 29 October 2019 rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there continued to be widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience
- People were not always receiving care and support which promoted their health, well-being and quality of life.
- Little work had been done regarding a more substantive training for staff to develop their knowledge, increase their skills and equip them to support people with dementia more effectively.
- Skills were lacking in person centred care, engaging with people in purposeful activity and responding effectively to the wider aspects of people's dementia related needs including communication, unsettled behaviours, nutrition and dysphagia (difficulty swallowing).
- The provider, since our last inspection, had introduced an induction, training and qualification policy. The current training matrix did not reflect all the training subjects identified in the policy. For example, person centred care was identified as a mandatory subject within the policy; this subject was not included within the training plan and received by staff.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing

- Following our inspection the provider told us they had appointed a Dementia Champion and their focus will be on improving dementia knowledge and awareness within the staff team.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- People's needs were not pro-actively assessed, reviewed and re-assessed. Associated care planning was not person-centred and did not refer to or reflect best practice or evidence-based guidance, to ensure effective outcomes were achieved.
- People living at St Marks were at different stages of their dementia ranging from early onset to advanced stages. There was no plan about how the service kept up to date with developments in this area that would ensure the care provided was appropriate and reflected best practice.
- Staff had a limited understanding of how dementia affected people in their day to day living. Appropriate strategies were not in place and staff did not know how to promote and keep for as long as possible, individual's interests and independence.

Supporting people to eat and drink enough to maintain a balanced diet;
- People were not always supported to eat and drink enough to maintain a balanced diet.
- People left to eat independently, had little interaction with staff and therefore did not receive the

encouragement or practical help they needed to eat more, either independently or with support. As a result, some people ate very little of what they were served. Staff did not explore this further or follow the provider's policy to offer an alternative, replacement or preferred snacks.
● Monitoring and management of people's nutritional needs were poor putting them at risk of dehydration and malnutrition. Some staff did not record accurately the amount of food or fluid consumed.

This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Meeting nutrition and hydration needs.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● The service did not always work well with other agencies to support people to live healthier lives and provide consistent, timely care.
● We found requests from healthcare professionals for specific monitoring in relation to individual's choking risk, and potential re-referral, were overlooked and not carried out. This placed people at significant risk to their health and welfare.
● Information and recommendation given by a healthcare professional in relation to relieving pressure and preventing skin breakdown had not been recorded and added to care planning arrangements. We saw the recommendation was not being carried out placing the person at risk of skin breakdown.
● Oral care plans for people were generic and not always reflective of people's actual oral health needs.
● One person had requested to see a dentist as they were experiencing hot and cold sensitive pain; nothing had come of this request. Their oral care plan did not reflect this person's needs.
● The provider told us they had not received a response to their request for a community dentist to visit. No consideration had been given for a staff member to take the person to a dentist for treatment.
●One person told us, "They always take me to the doctor," pointing out the surgery was located close by. Relatives confirmed they were kept updated on any health issues.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.
People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● The service was not working within the principles of the MCA, to support people to make decisions and choices in the least restrictive way.
● Electronic care plans contained generalised statements regarding people's capacity. Some were contradictory and did not reflect how a person might express themselves or indicate agreement, preference or choice.

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

● The premises remained hazardous in places and were not suitable to meet people's needs. The ramp leading from the corridor into the communal lounge had no handrail and presented a hazard to people with poor mobility.

● Bathrooms required repair and refurbishment and the garden did not provide a safe and comfortable outside space for people.

● Whilst some redecoration had taken place to a communal area with the addition of a television further improvement was needed to adapt the service in relation to design and decoration to meet people's needs. Such as colour, lighting, points of interest, sensory areas and assistive living technology.

● Further refurbishment was needed; decoration and furnishings were very shabby and tired looking.

Requires Improvement

Is the service caring?

Our findings

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

Our inspection on 29 October 2019 rated this key question requires improvement. At this inspection the rating has remained requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care

- Relatives described staff as polite and friendly. One felt improvement could be made to support their family to vocalise their needs more.
- Care was mainly task rather than people focused. Staff did not sit with people for a meaningful length of time. Staff did not always communicate clearly or in accessible ways that people could understand. This impacted on people's wellbeing and feeling valued.
- Insufficient staffing numbers; staff understanding of diverse needs and ability to communicate effectively were contributing factors.
- Staff walked past people seated in the lounge to carry out a care task without acknowledging people as they walked past. Staff sitting in the lounge, focused on completing their paperwork rather than engaging with people.
- A senior staff member was distracted with a mobile phone whilst assisting a person to eat.
- Where a staff member interacted well with a person, engaging in conversation about the person's interest, we saw how it had a positive impact on their wellbeing. They changed from sitting unengaged with their eyes closed to being alert and smiling.
- Staff were not always respectful of people's feelings and personal belongings. A person smiled as they spoke about their favoured soft toy. The soft toy was heavily soiled and needed to be washed and returned. After we raised this with the registered manager, we found it had been thrown away in the bin.

Respecting and promoting people's privacy, dignity and independence

- Good practice in respecting and promoting people's dignity was not consistent. Thought had not been given as to how people's dignity could be maintained when they were unable to be independent.
- We saw mealtimes were task led, rushed and not a positive, dignified experience for people. We saw actions carried out that were not good practice and did not demonstrate respect or dignity for people.
- A staff member was seen assisting two people with their meals at the same time.
- Some people struggled to eat independently; adapted crockery and cutlery was either not available or offered to assist people eat more independently and with dignity.
- Where a person was being assisted by a staff member to eat there was very little engagement; the pace was set by the staff member and rushed, with a large overloaded spoon of food being given before the previous mouthful was finished.
- People were not supported to wash their hands before eating; they were not provided with napkins or

condiments. A person had a toilet roll on their table to use as a napkin to wipe their mouth and fingers.
- People were not encouraged or supported to maintain their mobility.

Inadequate

Is the service responsive?

Our findings

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

Our inspection on 29 October 2019 rated this key question requires improvement. At this inspection the rating has 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; 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

Our inspection on 29 October 2019 found people's care plans were not current and did not contain the most up to date information about their needs. The registered manager recognised further work was needed to review and update care plans and told us at that time they were doing this.

This inspection found enough improvement had not been made.

- People's care and support was not planned and delivered in an individualised or personalised way.
- Our previous inspections as far back as 2017 have highlighted the service was not responsive to the needs of people related to dementia. Care plans did not inform staff of people's strengths and the type and level of support they needed to keep their best independence and promote their wellbeing.
- The service was not pro-active in making sure people did not experience loneliness. People who spent their time in their bedrooms had little or no stimulation, only that from staff performing a care task.
- One person told us, "I detest not being able to go out. I would like to get away from these four walls. I never thought I would end up like this, I hate every minute of my life."
- Feedback regarding the activity staff member was positive. They had started to gather people's life histories to help understand and get to know individuals. However, this information was not used to inform personalised care plans.
- There continued to be an absence of inclusive activity from 11:30 each day when the activity person finished, and weekends. A lack of meaningful activity and going outside led to people becoming agitated and emotionally distressed.
- Daily records did not give any indication of how the person's day was spent nor did they give any reference to their wellbeing. Where there were notes that showed the person had not had a good day there was no information as to why or how staff supported them at this time. This lack of records did not show if staff were providing personalised care which promoted people's independence and met their needs.

This is a breach of Regulation 9 of the Health and Social Care act 2008 (Regulated Activities) Regulations 2014 Person Centred Care

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the

Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● There was an inequality in supporting people with their communication. Where people were able to verbally communicate well with staff, their voice was being heard. However, where due to sensory loss, and/or dementia, improvements were needed.

● Picture menu cards had been produced since our last inspection, but we did not see these in use.

● One person did not have a communication plan in place despite being referred for a hearing assessment due to hearing loss.

● There was a failure to communicate effectively with a person who was deaf despite having picture sheets to help them to express mood, feelings and needs.

● This person was seated in the lounge and was clearly agitated. Two staff members were unable to communicate with them and ascertain what it was they wanted or needed. Both staff were asking questions, but the person was unable to lip read because they were wearing masks. Neither staff sought the communication cards from their bedroom nor used alternative communication methods.

Improving care quality in response to complaints or concerns

● There was a complaints system in place.

● Guidance was provided for people within the Service User Guide on how to make a complaint. This had been updated in August 2021. However, the guidance incorrectly stated the Commission would investigate an individual complaint.

● Since our last inspection there had been four complaints received which had been addressed by the registered manager.

End of life care and support

● People's care plans contained information relating to their end of life care and support. This included for one-person their preference of direct family involvement and support during final days.

● However, records were confusing for another person regarding their religious following. It stated the wrong faith leader to be contacted.

● Staff had not received training in end of life care.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question inadequate. At this inspection the rating has remained inadequate. This meant there continued to be widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This inspection found very little improvement had been made and the provider was still in breach of regulation 17.

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

- The registered manager, also the sole director of the registered providers company has placed, over the years, a heavy reliance on multiple external consultant support; two since our last inspection. This has meant there has not been a consistent approach to ensure effective development, improvement and sustainability to the quality and safety of the service.
- The registered manager/director did not demonstrate a good understanding of regulations, associated legal requirements or their responsibilities and blamed others for the failures and continued shortfalls. Their approach continued to be reactive with only short-term solutions to our previous inspection findings.
- Governance continued to be poor. Audits and checking systems were not robust or operated effectively. There was a continued failure to recognise and identify significant failings impacting on the quality of service provision, and risks to people's health and welfare.
- Daily 10 at 10 flash meetings included checking staff were wearing appropriate uniform. They failed to identify some staff attire did not comply with IPC, such as the wearing of jewellery and nail varnish.
- Daily walk around checks did not identify issues such as a broken foot operated clinical waste bin. They included mealtime experience checks which failed to identify people were not being supported to eat and drink safely or how they ensured mealtimes had a positive impact on people's health and wellbeing.
- The provider had recruited a further management team before this inspection. They had no assurance the new team had the required competencies and sector experience to run and improve the service effectively. For example, previous employments were not explored in depth to give assurance of previous satisfactory conduct and ability or a background working in residential care with older people who have dementia.
- There was no structured induction being undertaken in line with the providers policy to cover the responsibilities of the management and leadership team.
- The provider did not have a long-term development plan to plan for and drive improvement. The improvement plan in place did not include a clear vision for the service and how fundamental quality standards were going to be achieved, embedded and sustained to ensure compliance with regulations.
- Observation showed, despite the additional management team on duty, there was no effective leadership to oversee and direct staff on each shift and staff did not have the skills and support they needed to support

people living in the service.
● Gaps in the knowledge of the staff team were not identified or addressed.
● An electronic record system had been introduced. Staff were not familiar with the system and needed further training to operate it effectively. The broadband signal was weak in some areas of the home and therefore the handheld devices failed to work in all areas of the home.
● Lack of time and poor signal meant staff relied on memory to enter information about people's care retrospectively.
● The registered manager was entering people's risk and care planning data on to the new system. They had not ensured care plans, risk assessments and summary profiles were fully reviewed, re-assessed and revised during this process to ensure they contained current, accurate and relevant information.
● During this transition relevant and important information was getting lost. For example, information relating to people's swallowing difficulties and significant risk of choking was not transferred to the electronic system, which meant staff did not have this information and audit systems had failed to identify this.
● The registered manager/director had reviewed and revised policies. However, they were not always reflective of the service provided.

There continued to be a failure to recognise and identify significant failings impacting on the quality and safety of service provision and a continued lack of consistency in how well the service is managed and led. This is a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

At the last inspection the provider had failed to ensure people received a service that was person centred. This is a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This inspection found very little improvement had been made and the provider was still in breach of Regulation 9.

● The culture of the service was not an open and positive one.
● Staff were not informed of or engaged in an improvement plan and were not aware of their role within any improvement processes.
● There was still no plan about how the service kept up to date with developments in dementia care and other mental health conditions to ensure care provided was appropriate and in accordance with best practice. There continued to be a lack of recognition and understanding of the wider aspects of living with dementia and related needs.
● Insufficient attention was given to appropriately engaging with and involving people who had dementia. In general people living in the home had complex needs which had not been continuously explored or reviewed to ensure they could experience a meaningful, tailored and inclusive life as far as possible.
● Satisfaction surveys were carried out each year by the provider to gather people's views and experiences; the results returned from the survey were good overall. The registered manager/director was unable to demonstrate how comments or concerns received were considered or managed to drive improvement. For example, a request for transparent face masks to aid communication with lip reading for people who are deaf was not met.

This is a continued breach regulation 9 of the Health and Social Care Act 2008 (Regulated Activities)

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People were not being supported effectively to help them to eat and drink enough