Prime Life Limited

Mill House & Cottages

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Mill House and Cottages is a residential care home providing accommodation and personal care to 25 people aged 65 and over at the time of the inspection. The service accommodates people in two areas within the main building and has six bungalows adjoining this for people who wish to have an environment that better promotes their independence.

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

Risks to people's safety had not been adequately assessed or reviewed. We identified that equipment was in use that should have been removed from service due to safety issues. People were not protected in a safe environment. The premises were not maintained to a standard which ensured people were safe. We identified risks in the environment which had not been recognised or addressed by staff or the management.

The management of medicines had not improved since our last inspection and we found improvements were still required in record keeping, ensuring safe application of medicine patches and administration of covert medicines. People did not always receive their medicines on time.

There were widespread shortfalls in the training of staff to ensure they had the skills, competence and experience to provide good quality care and keep people safe. The mealtime experience for people was poor, staff did not promote choice to aid people's enjoyment. The provision of meals for people who needed the texture of them to be adapted was poor. Where people lacked the capacity to make decisions, detailed assessments of this had been carried out and best interest decision made in line with the law. A major refurbishment of the premises was underway to improve the environment and better meet the needs of people living with dementia.
We have made a recommendation the provider ensures catering staff complete training in the preparation of food for people who swallowing difficulties.

Staff did not always promote people's dignity to ensure their right to privacy was upheld. Improvements were needed to ensure all people were able to be as independent as possible. People were not always involved in all aspects of their care planning. Staff were kind hearted but were task focused in their support and did not always take the time to listen to people.

Stimulation, activities and opportunities to reduce the risks of social isolation needed improvement. People received minimal interaction from staff because they did not have the time or resources to provide this. Complaints records were unable to be located, however people, their relatives and visitors were clear who they could raise a concern to.

There was a lack of clear governance in the service and the provider did not have effective systems in place

consistently assess, monitor and improve the quality of care. This meant poor care was not identified and rectified by the provider. There had been an exceptionally high turnover of managers providing leadership to the service. Our two previous inspections have rated the service as Requires Improvement and the service is now rated Inadequate. We are therefore concerned about the overall governance of 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 requires improvement (Published 25 July 2019) and there were multiple repeated breaches of regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations. This is the third consecutive inspection the service has been rated as requires improvement or inadequate, and we have found breaches of regulations.

Why we inspected
This was a planned inspection based on the previous rating.

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

Enforcement
We have identified breaches in relation to the management of risks to people, management of medicines, staff training and competency, nutrition and hydration and management, governance and quality of care in the service.

We have issued a warning notice to the provider in relation to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
regarding the safe management of peoples medicines In additional to this, we have also issued a warning notice to the provider in relation to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 regarding good governance.

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

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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Mill House & Cottages

Detailed findings

Background to this inspection

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

Inspection team
This inspection was carried out by two inspectors, one of whom is a medicines inspector and an inspection manager.

Service and service type
Mill House and Cottages 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 very recently appointed a manager, although they had not yet registered with the Care Quality Commission.

Notice of inspection
This inspection was unannounced.

What we did before the 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 also spoke with professionals from the local authority quality monitoring and safeguarding teams.

During the inspection
We spoke to three people living at the service, a relative, and a close friend, about their experience of the care provided. We spoke with three members of care staff, the manager, two of the providers regional

directors, and the providers quality assurance manager. We reviewed the care plans and records for nine people, and medicines administration records for 12 people. We looked at two staff files in relation to recruitment and supervision and a variety of records relating to the management of the service. We also carried out observations of people receiving care and support in communal areas of the home, as well as medicines administrations.

After the inspection
We continued to seek clarification from the provider to validate evidence found and looked at data relating to staff training.

Inadequate

Is the service safe?

Our findings

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

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

Using medicines safely
At a focussed inspection in June 2019, and a responsive comprehensive inspection in January 2019, we found the provider had failed to ensure the safe management of people's medicines. This was a repeated breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was in breach of regulation 12 for the third consecutive inspection.

- The provider had not made sufficient improvements for managing medicines since the last inspection. Medicines were not always being managed safely.
- Staff did not understand the importance of administering time sensitive medicines at the correct time. For example, we saw one medicine, which should have been given with or after food, about to be administered before the person had had their breakfast. Another person with Parkinson's disease was prescribed a medicine to help with mobility at 8 am. We saw that they did not receive their medicine until 10 am on the day of inspection. Their records also showed many deviations away from the prescribed administration times. This meant these medicines may not have been safe or effective for people.
- We saw that staff did not ask people if they would like their 'when required' (PRN) medicines and therefore people did not receive any PRNs on the morning medicines administration round.
- We observed at lunch time that one person repeatedly said they had back pain and was in obvious discomfort. Staff did not offer the person pain relief medicines until our inspector intervened and spoke to the senior carer on duty.
- At our last inspection we saw PRN protocols to assist staff to understand how and when to administer PRN medicines were not always person specific. On this inspection, we saw some but not all protocols had been updated with person centred information, but there was still no support for staff to assess whether people's symptoms had improved following administration of a PRN, especially for people who were not able to verbally communicate.
- At our last inspection we saw that people who received their medicines covertly (hidden in food or drink) did not have appropriate guidance on how the medicine could be administered safely and was not person or medicine specific. On this inspection we found this had still not been reviewed.
- At our last inspection we saw people who were on medicine patches had incomplete or no records of where their patch was placed on their body. On this inspection we found records were still not being completed, and therefore, we could not be assured the site of the patches was rotated as per manufacturer recommendations.

● At our last inspection we saw care plans did not always have guidance for staff to monitor side effects and effectiveness of medicines. On this inspection we saw that this was still the case, and staff were unaware of some of the complications to look out for high risk medicines such as blood thinners.
● Many liquid medicines, eye drops, and creams did not have a date of when they were first opened. Therefore, we could not be assured that the medicines were still suitable for use.

This was a continued breach of Regulation 12 (g) (Safe Care and Treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Medicines were stored securely, and medicines trolleys were locked when left unattended in communal areas.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
At a focussed inspection in June 2019, and a responsive comprehensive inspection in January 2019, we found the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a repeated breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was in breach of regulation 12 for the third consecutive inspection, in relation to safe care and treatment.

● People remained at risk from equipment and areas of the premises that had been poorly maintained, regular checks were not in place to identify damage so that action could be taken. We found significant damage to electrical equipment, safety railings as well as exposed hot water pipes, all of which could have caused very serious injury.
● For example, we found that the external sheath of an electrical wire for a person's pressure reliving air mattress, had been damaged, exposing the internal copper wiring, but remained plugged into the mains supply. In addition to the risk of electrocution, the air mattress was not working and placed the person at risk of developing a pressure ulcer. We reviewed the daily records of checks for this equipment and found they had not been completed for more than six weeks.
● A safety fence between the garden area and the river was damaged in two places, meaning this would lean over should a person fall or push on it. A bathroom that was used regularly by one person for showering, did not have a call bell with a pull cord, that could be used to signal for assistance or if there was an emergency.
● A refurbishment programme was underway at the service, however rooms that were not safe for public entry, and had signs on them to this effect stating they should be locked, were left unlocked.
● We found that some care plans contained contradictory information when assessing risks to people and the actions to be taken to mitigate them. Information for staff to use was not always accurate. Care plans had not always been reviewed or update following an incident such as a fall.
● For example, we saw in a moving and handling plan, that one section directed staff to use a hoist in an emergency only. However, another section stated to use the hoist for all transfers and not to use their walking frame. This care plan also gave contradictory information on whether a small or medium sized hoist sling should be used. We checked this person's room and found their walking frame had not been taken away and was by their bed. This put the person at risk of fall or injury should they reach out to use it.
● We also saw that for one person, their care plan stated they were not at risk of falling out of bed. Therefore, would not require bedrails. Another section of their care plan for sleeping, stated that bed rails should be used. This put the person at risk of either falling from bed, being unable to leave their bed depriving them of their liberty or pose a risk of them climbing over the bed rails which would be unsafe.

● We found widespread examples of when wrong dates had been entered to records in error, that had not been identified through quality audits. This meant that reviewing the progress or deterioration of a person's health and wellbeing was difficult to measure.
● Records relating to emergency situations, such as a missing person or emergency evacuation had inaccuracies. This included detailing the wrong room number, and a missing date when the record was completed, to indicate when a review was required.
● Records relating to incidents and accidents were not complete. We saw correspondence from the ambulance service relating to a person they had attended to and taken to hospital following a suspected serious injury. However, the details of this incident had not been logged or reviewed by the service.
● The service did not have an effective and established system in place to monitor incidents, accidents and risks from premises and equipment. Information had not been consistently reviewed to monitor for trends and themes, or the shortfalls that we identified during inspection. The service had six different managers since October 2018 and this factor compounded this.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This is a continued further breach of regulation 12 (a), (b), (c), (d) & (e) (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The manager and regional directors demonstrated an open culture towards addressing these shortfalls. As we identified these concerns during our inspection, we asked the manager to take action to address them. The manager acted without delay and took action to make repairs and review records to make changes.

Preventing and controlling infection
At our last focussed inspection in June 2019, the provider had failed to ensure that the premises had been kept clean and good infection control practice was followed. This was a breach of regulation 15 (premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found improvements had been made, and the provider was no longer in breach of this regulation.

● Since our last inspection the provider had deployed additional cleaning staff to ensure that the home was kept clean and free from the risk of infection. We found the home to be much cleaner, and free from lingering malodour.
● We observed that staff wore personal protective equipment (PPE) when supporting people or carrying out task such as laundry.
● Although we found improvements had been made, staff training completion of infection prevention and control (IPAC) needed to improve. According to the providers training records, five staff had not yet completed training in IPAC, and three staff had not renewed their IPAC training within the providers stated intervals.

Staffing and recruitment
● People and their relatives told us there were sufficient staff employed to meet people's needs and keep them safe. We found however that although there were enough staff to keep people safe, they were not effectively deployed, and staff were task focussed. We observed that people who were up and dressed on our arrival at 8 a.m., did not start to receive their breakfast, or their medicines until almost 10am.
● Records showed that all staff working at Oak Farm had undertaken checks with the disclosure and barring

service and obtained suitable references to vouch for their character. References had also been obtained although we found that for one staff member gaps in their employment had not been recorded as discussed during their interview. The provider took action during our inspection to account for this gap.

Systems and processes to safeguard people from the risk of abuse

● Staff training and knowledge of safeguarding procedures were not sufficient to promote good practice in keeping people safe from the risk associated with abuse.

● Staff we spoke with were aware of who to report any safeguarding concerns to within the service but were not aware of any other statutory bodies they could report to, such as the local authority or CQC. The providers training matrix showed four staff had not completed safeguarding training, and two staff were overdue in updating their competence.

● People told us they felt safe, relatives and visitors we spoke with confirmed this.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

Staff support: induction, training, skills and experience

- The provider had not ensured that essential training had been completed or renewed by all staff. We found widespread shortfalls in the monitoring and planning in compliance of staff training and checks of the competency. This included high risk activities such as moving and handling people, infection prevention and control, health and safety and safeguarding vulnerable adults.
- For example, three staff had not completed training in safe moving and handling, and a further seven staff needed to refresh their training. We observed occasions when staff did not follow best practice when supporting people to transfer, for example applying the brakes on a wheelchair as the person transferred to an armchair. 13 staff had not completed training in dementia care, although most people at Mill House and Cottages were living with dementia.
- Staff we spoke with had shortfalls in knowledge they needed to ensure their practice was safe. This included understanding of the risks associated with medicines and the need for timely administration and the reporting of safeguarding matters. Some staff felt that previous managers at the service did not have the knowledge or experience themselves to lead and develop staff.
- We asked the manager and provider to address this shortfall to prevent further risk to people. The manager provided us with reassurance and details of actions to ensure staff who were not suitable experienced and trained were not working without supervision.

This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet

At our comprehensive inspection in January 2019, we found a breach of Regulation 14 (Meeting nutritional and hydration needs) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured that these were adequately monitored to promote people's health.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 14 for the second consecutive inspection.

- We found the monitoring of people's intake of food and fluid had improved since our last inspection. However, we found that staff training, competence and practice, and the dining experience at the service required improvement.
- The providers records showed that 12 staff had not completed nutrition training, which including training in how staff assist people to eat. We observed occasions where staff practice was poor. For example, we saw

a staff member who had not completed nutrition training, support a person with very high needs, frequently turn to watch the television, rather than remain focused on the person they were helping to ensure they were swallowing safely.

● We observed that staff made assumptions that people had access to drinks when this was not the case. We observed one person being served a meal, but was not offered a drink, when they asked for one, they were told they had one, but this in fact belonged to a person no longer sitting at the table.

● People were not always offered a choice of drinks with their meal. We observed another person ask for water with their food, but was told they had squash on the table, and the carer walked away. Another person was brought a cold drink but turned to the inspector to say they wanted a cup of tea after their lunch, not squash, they hadn't been asked.

● People were asked to choose their meal during the morning from a menu list. This was not provided in pictorial format for people living with dementia to choose from. When staff brought the plated food choice at lunch time, they did not check that the persons choice was still the one they wanted.

● Improvements needed to be made for meals that required to be pureed for people who had difficulties swallowing. We saw one meal that been pureed, had not been done so with the different elements separated. The meal presented looked unappetising, and the person did not want to eat it, but was eating a meal that their relative had brought in from home.

● Kitchen staff had not received any training in the preparation of specialist diets requiring textures to be altered. The manager told us that staff had been booked to go on this training soon.

We recommend the provider ensures that staff engaged in food preparation have received specialist training in the preparation of food for people with swallowing difficulties and ensure best practice guidelines are followed.

● For people living on the Mallard unit, there was insufficient space for them to have an option to sit at a dining table to eat. Some people were not offered a choice of where to sit, and had their meals provided to them whilst sitting in an armchair with a small over the lap table to use. There was limited space for staff to support people who needed assistance. The opportunities for social interaction and enjoyment were limited by this.

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

● People who were able to share with us their opinion of the food provided told us it was enjoyable and well cooked.

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

● Before people started using the service, their needs were assessed by a manager to ensure the service would be suitable and their needs could be met.

● Needs assessments covered areas including medicines, personal care, mobility, eating and drinking, continence, skin care and making decisions. Information gathered at these assessments and referral information from the local authority were used to draw up care and risk management plans.

● Since our last inspection, people's care and support needs had been reassessed. However, needs assessments were not always clear, and contained conflicting information. See action we have asked the provider to take in our safe and well-led key questions.

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

● Since our last inspection, the provider has started a comprehensive refurbishment plan of the home. This

work was ongoing and had enhanced the environment of the home to be brighter, and better suited to the needs of people living with dementia. Paint schemes had been designed to aid people recognise and distinguish different areas of the service.

● However, further improvements were needed to ensure that the environment was safe for people that had not been identified. For example, providing lockable spaces in people's rooms to secure toiletries and topical creams and heating in bathrooms where people have raised that they get cold. You can find further details about what we found in the safe and well led key questions.

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

● People were supported to assess healthcare services. Each person was registered with a GP. At our inspection visit we observed a visiting district nurse providing care and treatment to people.

● We received feedback that communication to families and friends who supported people to attend health appointments had on occasions been insufficient resulting in confusion and inconvenience, but that this had improved recently.

● Records showed that people had received care and treatment from healthcare professionals including, dentist, pharmacist, hospital and staff from community health teams including district nurses.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● Staff we spoke with had a basic understanding of the MCA and DoLs. However, records showed that staff training in this topic was not sufficient. Seven members of staff had not completed this training, and a further two had not refreshed this training in line with the providers stated interval.

● Where people were deprived of their liberty, the home worked with the local authority to seek authorisation for this to ensure this was lawful.

● We found that assessments of people's capacity, and best interest decisions taken where done so in line with the law. These were clearly detailed in peoples care records and involved those people with the legal powers to do so.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. 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

- We observed that staff were mainly kind and caring towards people whilst supporting them. Relatives and visitors, we spoke with told us most staff were kind, caring and good at their jobs, but this was not consistent. We were told that over the previous few months, managers had started to address this.
- Staff were at times task focussed and did not take the time to ensure choice was offered to people or treat them with respect. Interactions between staff and people were very limited. People were not always offered the choice of what TV or Radio station they wanted, what time they wanted to eat. We observed people being moved around the service in wheelchairs without staff explaining they were about to move, or where they were going. Similarly, people were sometimes transferred using a hoist without this being explained to them.
- Whilst we observed that staff and the management team were kind to people, the lack of sustained improvement since the last inspection meant we were not reassured the provider and staff were sufficiently caring. The service has failed to maintain regulatory compliance over a period of 14 months, which meant people had been receiving inconsistent or poor care for an extended period of time.

- Care plans contained information about a person's life history, we saw that recently, photograph posters had been placed on people's bedroom doors that were themed to reflect their favourite things.

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

- Staff did not always take the time to ask people for their view or choice before providing them with support. Staff were often focussed on completing the task rather than wait for a response. For example, we saw the cook tell one person the raspberries they had requested had been delivered and were available for desert. The person was excited about this, however, staff came along and asked if she wanted desert, to which they said yes, but staff did not wait around to hear what they wanted and returned with a hot desert. The person looked confused and the inspector intervened to point out the person had already been told raspberries were available.
- Meetings with residents and families had not taken place for some time. The manager was unable to locate records from previous meetings held by previous managers. They told us this was an immediate area they wanted to address.
- Reviews of people's care included the person where appropriate, and those with the legal power to make decisions of behalf of a person. One person we spoke with told us they had been fully involved in planning their care, and that staff always checked with them first before carrying out something on their behalf, such as arranging a medical appointment.

Respecting and promoting people's privacy, dignity and independence

● Improvements needed to be made to ensure that people's privacy and dignity were maintained. For example, we saw that people were given drinks in plastic cups, or beakers with integral straws when they did not need these, for staff convenience, rather than a china cup or mug.

● We observed that staff were not always discreet in communal areas, for example one person who needed a medicine patch had this applied by partially lifting up their top in a lounge area, instead of doing this when the person was in their room or other private place.

● We received mixed feedback about how staff supported people to be as independent as possible. We observed t staff supporting people with higher levels of need, encouraging them to be independent for example in completing a jigsaw puzzle. One visitor we spoke to told us that staff could be more consistent in prompting and helping people to be as independent as possible. For example, ensure that shaving equipment and towels were regularly laid out so the person could shave themselves on waking, rather than waiting for staff to come and do this.

● People with a greater level of independence were able to live in the adjoining cottages which were self-contained and offered cooking facilities. People were able to choose the level of support they wanted. Staff had worked with one person to independently access community resources and facilities, including the café in the village.

Requires Improvement

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 remained the same. This meant people's needs were not always met.

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

- Whilst people and their relatives were involved in the planning of their care, people's care records still required further improvement.
- Care plans contained conflicting information about how people needed their care provided. When updates were required after changes occurred, we could see that staff had added dates to show the care plan had been reviewed. However, there were no details to show this had been reviewed with the person, or that their views had been asked for.
- People living at the home were offered minimal choice in how they wanted to spend their day. We saw that many people with limited mobility were taken from their room in the morning to a communal sitting area, where they remained for the duration of the day. These people were not offered opportunities to sit elsewhere in the home or go outside to the garden area.

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

- Activities and opportunities for people to engage in them were limited. Relatives, visitors and staff all told us that more could be done to provide daily stimulation as well as trips away from the service. Staff told us they did not have the time to provide organised activities.
- During our inspection we saw that activities were limited to jigsaw puzzles, a board game for one person and brief conversations.
- People were able to have visitors without restriction and visitors were able to stay and have a meal with those they were visiting.

Improving care quality in response to complaints or concerns

- At the time of our inspection, the manager was unable to locate any records in relation to complaints, compliments of negative feedback. People, their relatives and visitors told us that they felt able to raise concerns and complaints, and these had been responded to in the past.
- People, their relatives and visitors knew who they would go to if they wished to raise a concern.

End of life care and support

- Care plans contained information about peoples wishes and needs to be taken into consideration at the end of their lives. They also stated where a person did not wish to discuss this.
- Staff needed further training in supporting people at the end of their lives to ensure that this was dignified, pain free and followed best practice. There were six members of staff who had not completed this training.

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.

● Improvements had been made to the signage to improve orientation for people living with dementia. Notices to advertise activities taking place had been produced in pictorial and symbol formats.

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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people: Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; 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

At our last two inspections in January and June 2019, we found the provider had failed to ensure systems for monitoring and improving the quality and safety of the service and having regard to the accuracy of records were not operating effectively. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Not enough improvement had been made at this inspection and the provider remains in breach of regulation 17. (Good governance) The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Multiple ongoing concerns were found during this inspection and the provider remained non-compliant with the regulations. Progress since our last inspection had not been sufficient, and we identified that some areas had regressed in quality or compliance.
● The service did not have a manager in place that was registered with the CQC since October 2018. Since that manager left, the provider had recruited four managers. The interim periods where no manager was in place were overseen by the providers area managers. This high turnover had meant progress to meet the regulations had been curtailed. Staff, relatives and visitors told us the turnover of managers had a negative impact on the home.
● Staff morale had been impacted by the turnover of managers, with some staff feeling teamwork was poor and needed to improve. Relatives and visitors told us that there was variance in the quality of staff and that some needed support from an experienced manager.
● The provider had a range of audits to monitor the quality and safety of the service provided. Regular audits included, care planning, training, the environment, medicines and health and safety. However, these had not been effective in picking up the areas of concern we found in these areas.
● The service did not always promote a person-centred culture that ensured people achieved good outcomes. People did not receive a consistently good level of care because the risks to their safety and wellbeing were not always mitigated to protect them from the risk of harm.

● Care records were not always accurate and had not been always updated to reflect a change in people's needs. This meant there was a risk people would receive inconsistent and unsafe care.
●The service has a history of non-compliance with the regulations and has not improved their rating to Good after three inspections. This showed the provider did not have an effective system in place to continually learn and make sustainable improvements to the care people received.
● Meetings for people and their families had not taken place. Satisfaction surveys had not been sent out either so that people could share their views. There had been minimal engagement with people and their relatives by the previous manager which caused them concern. We were told that the new manager had already addressed this which had a positive impact.

This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● The providers regional directors and managers have kept in regular contact with the Care Quality Commission since the service was rated requires improvement following our inspection in January 2019. They were responsive and open during the inspection process, and for subsequent requests for information.
● The providers regional directors and managers had engaged with community professionals and local authority quality monitoring officers openly at regular meetings to discuss the quality of care at the service.
● The current manager had only been in post for two weeks at the time of our inspection. We received positive feedback from staff, people and their relatives and visitors of the initial positive impact they had and were confident of improvement under their leadership.
● The provider had ensured their previous inspection rating was on display for people to access. Notifications had been submitted to the CQC as required.

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 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There were risks to people's safety associated with the services environment and equipment used. Risks to people, and the planned actions to help mitigate them were not adequately planned, adhered to or monitored. 1, 2 (a) (b) (c) (d) (e) (g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs. Staff did not have sufficient skill, experience or training to support people to eat safely, or provide food with altered textures. Oversight of mealtimes did not ensure the nutritional needs and hydration needs of service users were met. 1, 2 (a) (b) 4 (a) (c) (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient suitably qualified, competent, skilled and experienced persons deployed to meet people's needs safely. Regulation 18 (1) and 18 (2) (a) (b)

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 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA RA Regulations 2014 Safe care and treatment. The provider did not ensure the proper and safe management of medicines 1,2 (g)

The enforcement action we took:

We issued a warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA RA Regulations 2014 Good governance. Systems for monitoring and improving the quality and safety of the service and having regard to the accuracy of records were not operating effectively. 1, 2 (a), (b), (c) (d) (e) (f)

The enforcement action we took:

We issued a warning notice