Minster Care Management Limited

Duncote Hall Nursing Home

Inspection report

Duncote Hall
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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?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Duncote Hall is a residential care home that can provide long and short-term residential nursing care for up to 40 older people, including people living with dementia. At the time of inspection 34 people were using the service.

People's experience of using this service and what we found
We found evidence of ineffective systems and processes in how the provider delivered and monitored the quality and safety within the service.

Risk to people's safety and health were not always identified, assessed and managed. Staff did not always follow people's risk assessments. Peoples personal emergency evacuation plans (PEEP's) did not always contain the information required for staff to support them safely in the event of an emergency. People did not have appropriate risk assessments for the use of equipment and the equipment was not always used correctly.

The provider did not have suitable systems in place for staff to recognise and report abuse and injuries to people. The provider did not investigate incidents fully.

Safe staff recruitment processes were not followed to protect people from unsuitable staff. Staff recruitment files did not contain all relevant information to demonstrate that staff had the appropriate checks in place.

There were not always enough care staff to meet people's needs. People and staff told us that staff did not have the time to talk to them.

Medicine management system was not effective or safe. Medicines had not been given as prescribed, and adequate medicine stock was not kept.

The Mental Capacity Act principles were not followed. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

People did not receive person centred care. People's care files were not kept up to date and relevant to the person. Information about people's needs, health conditions, choices and preferences were not always documented. People's care was not monitored or kept under review.

People's records were not completed fully and there were gaps in people's daily monitoring charts.

The environment was not always kept clean and there were no dementia friendly signage on people's bedroom doors or on walls throughout the building.

People's dignity was not always maintained or respected. Staff did not always refer to people in a respectful way.

Daily activities were organised which some people enjoyed. However further action was needed to ensure people were not at risk of isolation and lacked meaningful engagement.

People and relatives told us they knew how to make a complaint. There were procedures in place for making compliments and complaints about 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
The last rating for this service was Good (published 26 February 2019).

Why we inspected
The inspection was prompted in part by notification of a specific incident. Following which a person using the service died. This incident is subject to a criminal investigation. As a result, this inspection did not examine the circumstances of the incident.

The information CQC received about the incident indicated concerns about the management of unsafe medicines management. This inspection examined those risks.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well led sections of this full report.

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 food and fluid, infection control, safe care and treatment, staffing levels, governance, person centred care, respect and dignity, staff recruitment and environmental concerns.

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.

Special Measures:
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?

Inadequate

The service was not 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

Duncote Hall Nursing 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.

Inspection team
The inspection team consisted of two inspectors, one assistant inspector and one specialist nurse advisor.

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

The service did not have a manager registered with the Care Quality Commission, the company had a clinical lead who was covering the registered manager role, while the company recruited to this post. We will refer to this person as the manager within this report. 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
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We reviewed information we had received about the service since the last inspection. This included statutory notifications that the provider had sent us. A statutory notification is information about important

events which the provider is required to send us by law.
We contacted the health and social care commissioners who monitor the care and support that people receive.

We used all this information to plan our inspection.

During the inspection
We spoke with five people who used the service and four relatives about their experience of the care provided. We spoke with six members of staff including the nominated individual (who is responsible for supervising the management of the service on behalf of the provider), the manager and care staff.

We reviewed a range of records. This included 12 people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with two professionals who regularly visit the service.

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.

Systems and processes to safeguard people from the risk of abuse

- The provider did not have suitable systems in place to ensure staff recognised abuse and followed procedures to report injuries.
- The provider did not conduct investigations for safeguarding incidents such as unexplained bruising. Staff had not completed body maps detailing the location of the bruises found on two people. This meant the cause of the bruising had not been identified and measures had not been put in place to reduce the risk of re occurrence.
- Although Staff had completed safeguarding training and the safeguarding adults' policies was accessible to all. Staff had not followed procedures to report potential abuse such as unexplained bruising.
- Some people were unable to use call bells to seek staff support. There was no evidence hourly checks were undertaken as planned for these people. Therefore we could not be assured people's safety was being monitored by staff.

The provider failed to have suitable systems in place to protect people from potential abuse or improper treatment. This is a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment.

Following the inspection visit the provider told us they would ensure all people had a skin record, they would implement a full audit of body maps and would investigate all unexplained bruising.

Assessing risk, safety monitoring and management

- People were put at risk of harm as staff failed to follow risk assessments.
- One person's care plan instructed 'staff to follow them with a wheelchair if they were unsteady on their feet'. However, during our inspection, staff did not follow the care plan as directed and the person fell. Another person whose risk assessment stated they required their call bell within reach to ensure their safety, did not have their call bell within reach. This failure to follow risk assessments placed people at risk of harm.
- Another person whose risk assessment stated they required their call bell within reach to ensure their safety, could not reach their call bell. This failure to follow risk assessments placed people at risk of harm and serious injury.
- People did not have appropriate risk assessments for the use of bedrails. One person's risk assessment stated a 'bed bumper [padding to bedrail] will not be used.' However, on the day on inspection we observed bed bumpers being used. Another person was found with their legs over the side of their bed rails, their risk assessment did not identify this risk. Measures had not been put in place to protect the person from the risk

of a fall from their bed or to prevent the person from climbing over their bedrails and becoming trapped.
● Gaps between bed sides, bed frames and mattresses had not been identified. This meant people were at risk of entrapment.
● Equipment used to reduce risks to people, were not used correctly. One person had a specialist mattress to reduce the risk of skin damage. This was on the wrong setting for their weight, which increased their risk of skin damage and developing pressure ulcers. These are preventable if managed correctly.

The provider failed to ensure people's risks were being assessed and managed appropriately. This is a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Safe care and treatment.

Following the inspection, the provider told us they audited and ensured all pressure mattresses were set on the correct setting, bed rails and bed bumpers were audited and new properly fitted bumpers were purchased. The provider also completed an audit of call bell response times.

● Peoples personal emergency evacuation plans (PEEP's) did not always contain the information required for staff to support them safely in the event of an emergency. PEEP records we looked at stated in case of fire "use slide sheet [moving and handling equipment] and wheelchair" There were no further instructions for staff on how to safely move the person.
● Fire equipment was not always accessible to staff. The fire evacuation slide [used to support people down the stairs] was kept on the ground floor in a store room. Staff were not aware the fire slide was there. This put people at risk of an unsafe evacuation in the event of a fire.
● The environment was not always safe for the people living at Duncote Hall. For example, we found the cellar door left unlocked, there were steep concrete stairs and ant poison accessible. We also found a store room door with no lock that had a tin of paint and exposed wires within it. We brought this to the attention of the provider who put locks on all relevant doors during our inspection.

The provider failed to ensure the environment was safe by not locating and maintaining equipment correctly. This is a breach of Regulation 15 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Premises and equipment.

During the inspection the provider moved the evacuation slide upstairs and secured it to the wall.

Staffing and recruitment
● Appropriate pre-employment checks on new staff members did not take place. This put people at risk. The service did not always follow the provider's recruitment policy. Staff recruitment files did not contain all relevant information to demonstrate that staff had the appropriate checks in place.

The provider failed to ensure all staff had undergone the relevant recruitment checks and had the skills and competencies to provide safe care. This is a breach of Regulation 19 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Fit and proper persons employed.

● There were not always enough care staff to meet people's assessed support needs. We observed call bells not being responded to in a timely manner, people being left without staff for periods of time and people not receiving care for long periods of time.
● One staff member told us, "Staffing levels vary, sometimes there are not enough staff. It's not about the quantity it's the quality. This is an issue if staff don't know what they are doing as they don't know people's needs." Another staff member said, "We have five agency [members of staff] at the moment, it's like a race,

we are always rushing trying to get things done. Residents want to talk, and we don't have the time."
● A person told us, "They always seem short on staff."

The provider failed to ensure there were sufficient numbers of care staff deployed to meet peoples assessed care and support needs. This placed people at risk of harm. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing

Following the inspection, the provider increased staffing levels.

Using medicines safely
● People did not always receive their medicines in a safe way. Staff did not always follow the provider's medicines policy.
● One person who required medication for a complex health need had not received the correct medicines on many occasions. This meant they were at risk of serious harm.
● People who were prescribed 'as required' medicines, did not always have protocols in place to instruct staff when to give these medicines. This put people at risk of being given medicines when they were not required.
● One person told us, "I was unable to have my [medicine name] yesterday as it had run out." Medicine stock checks were not being carried out for certain medicines, this meant people's health was put at risk because medicines were not available to be administered as prescribed.
● One staff member told us, "We have run out of supplies [medicines, incontinence pads and dressings for wounds], things can run down, and nobody tells you."
● Medicine administration records (MAR) had handwritten changes on and did not clearly state what route medicines were to be administered. For example, whether orally or via Percutaneous endoscopic gastrostomy (PEG) tube (This is a feeding tube into the stomach, where a person is unable to consume food, drink and medicines orally), this meant there could be errors made in the administration of certain medicines.

Preventing and controlling infection
● Areas of the home were not clean such as stairways, people's equipment and pillow cases.
● Cleaning records for people who had a PEG were not consistently completed. One person's daily records for their PEG site had not completed for two days. This meant people were at risk of infection, pain and discomfort.
● Some people required staff support to clean their dentures. We found dentures were left in dirty water and had not been cleaned for some time.
● Staff told us, and records confirmed they had completed training in infection control. Information about how to prevent the spread of infection such as effective hand washing was available in the service.

Learning lessons when things go wrong
● Accidents and incidents had not been appropriately reviewed. One person who had fallen twice from a chair recently in the conservatory was left sitting in the chair without support on the day of inspection. The risk assessment and care plan had not been updated, and measures had not been put in place to reduce their risk of falling.

The provider failed to ensure that proper and safe management of medicines were completed. Incidents affecting people had not been reviewed, investigated and monitored, and procedures relating to infection control had not been followed. These are a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Safe care and treatment.

Following the inspection, the provider completed daily medicines audits to ensure people had the required medicines in stock.

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 good. 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.

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

- Some people had no written care plans in place. This meant that staff did not have the information required to care for people safely or meet their assessed needs.
- A person who had complex health needs did not any care plans in place detailing how their needs were to be met. Not all staff were aware of the person's needs, therefore staff could not deliver care in line with best practice due to the lack of guidance being provided to them.
- The provider had not assessed, and care planned for one person who was at very high risk of skin damage. There were no skin care plans in place that instructed staff how to support them.

The provider failed to assess and plan for the delivery of care to keep people safe. This is a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Safe care and treatment.

Following the inspection, the provider completed a short-term care plan for all people living at Duncote Hall.

- People's needs were not fully assessed and recorded prior to them moving to the service. Some people's care plans included some information about people's needs and choices, but these were lacking in detail. This meant that staff did not have information to deliver good quality care based on people's needs and choices.

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

- Not all people who were at risk of malnutrition and dehydration had the necessary paperwork in place, such as monitoring forms, action plans and risk assessments. This meant people were at risk of not having enough to eat and drink.
- Some people had lost a significant amount of weight over the past six months and, the rate of weight loss was not effectively monitored. People who were assessed as needing weighing weekly were not weighed as required. This meant measures to reduce people's weight loss were not promptly put in place and people were put at further risk of weight loss with no action being taken.
- Fluid intake records were not routinely reviewed. For example, records showed some people did not have enough to drink for several days to keep them adequately hydrated. There was no evidence action had been taken to address this. This put people at risk of dehydration.

● People told us they did not have enough to eat. Food portions were small and when people requested a second helping, this was not available as not enough food had been cooked.
● One person told us, "As we have no kitchen on site, for my breakfast I can only have cereals as I get up at 6.30 and the kitchen in [another location] only opens at 8am. I would like to have bacon."

The provider failed to ensure that people were in receipt of suitable food and hydration to sustain good health. This is a breach of Regulation 14 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Meeting nutritional and hydration needs.

Following the inspection, the provider completed action plans for all people whose food and fluid targets were not being met.

Supporting people to live healthier lives, access healthcare services and support. Staff working with other agencies to provide consistent, effective, timely care
● People's plans of care did not contain clear information about people's needs and conditions, which meant staff were unaware of people complex health needs. Information was not available to pass on to emergency services. This meant people were at risk of their medical needs not being effectively met.
● Daily handover forms did not have all the information of health appointments attended or medical recommendations. For example, staff did not document follow ups or actions needed from doctor appointments. This meant there was a risk of important health tasks not being completed and people being put at risk of their conditions deteriorating.

The provider failed to ensure all the necessary information was recorded to meet people's needs. This was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Person centred care.

● The manager ensured people were supported to have annual health checks with their GP. The GP visited the home weekly to see people as required.

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.
● MCA's and best interest decisions had not always been completed. For example, when two people shared a room. This meant their preferences and wishes for sharing a room had not been considered.
● The service recorded in some people's records that they lacked capacity however this was not consistent

and did not provide clear guidelines for staff.
● Where people were deprived of their liberty, the manager worked with the local authority to seek authorisation for this to ensure this was lawful. Records confirmed this.

Adapting service, design, decoration to meet people's needs
● There were no dementia friendly signage throughout the home so people could easily find their way around the home and to their bedroom.
● One person had to be cared for in bed as there was "no suitable seating" within the home.
● People's rooms were very personalised, and they told us they had been involved in choosing the decorations and objects in their rooms.

Staff support: induction, training, skills and experience
● The provider had a staff training plan to identify when staff required training. Staff had their competencies checked to ensure they were confident and competent to carry out their roles.
● New staff completed induction training, which included working alongside more experienced care staff.
● Staff told us they felt supported. One staff member said, "I feel quite well supported, the management are pretty good.

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 good. At this inspection this key question has now deteriorated to Requires improvement: This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- Some staff did not communicate with people effectively. For example, a person dropped their drink and became distressed, the staff member who cleaned the spillage did not reassure or talk to the person.
- Care records did not evidence people received good quality care. For example, the records for a person who was cared for in bed showed staff had supported them with [personal] care at 7am, the next time this person received care again was at 6pm. A gap of 11 hours. The same persons records showed on a different day there was a 6-hour gap between times of care given.
- A person who was supported in bed could not summon staff assistance should they need it, as they as they were unable to use their call bell. Alternative means had not been explored and the frequency staff should check them was not recorded. This person could have needed support and they had no method of summons it and no regular checks on them were being carried out.
- A person told us, "I ring my call bell but they [staff] don't always answer so I have to use my landline to phone the service and ask to speak to a nurse." Another person said, "I ring my call bell for support to use the toilet, sometimes I have to wait a while."
- Care plans did not always contain enough information to ensure people were supported well. For example, a person who had a catheter [a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid] in place did not have any information within the care plan on when/how to change it, risks associated with having a catheter or any bowel assessments.

People did not receive person centred care and treatment that was appropriate to meet their needs and reflect their personal preferences. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person Centred care.

Respecting and promoting people's privacy, dignity and independence

- People's dignity was not always maintained or respected. For example, a privacy screen in a shared bedroom was not big enough to go around the bed and there were gaps in the screen. Peoples care plans did not have information on how to ensure privacy was respected.
- One person's bathroom door did not close, this meant they did not have the privacy required when using the bathroom.
- We saw staff cleaning people's rooms and talking to each other when the person was still asleep. Staff did not respect their conversation could disturb the person's sleep.
- Staff did not always refer to people in a respectful way. The daily notes completed by care staff contained

undignified language, and we heard staff referring to people disrespectfully.

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

● We saw people being transferred using hoists, staff were kind and communicated with the person throughout the manoeuvre.

Supporting people to express their views and be involved in making decisions about their care
● People and staff told us that staff did not have the time to talk to them. One staff member told us, "People would benefit from us [staff] having more time with them." Another staff member said, "Staff are task focussed they don't have time to spend with people."
● The provider had not completed regular residents meeting, to support people to discuss any concerns or suggestions.
● Some relatives told us they were involved in care plan reviews.

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 good. At this inspection this key question has now deteriorated to Requires improvement: This meant people's needs were not always met.

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

●People's care plans did not provide staff with adequate guidelines on how to meet people's needs and preferences. These did not always include people's social, cultural or spiritual needs or their preferences as to the gender of staff to support them.

● Not all care plans included information about the person's life histories, important events and other people who were important to them. The lack of information about people meant staff missed opportunities to have meaningful conversations about things that were of interest to people

● The provider had not ensured people's needs had been regularly assessed or reviewed. People's care plans did not always detail or reflected people's current needs.

● Some people's care plans contradicted information from their risk assessments. For example, a person falls risk assessment classed them as high risk, however their care plan stated a medium risk. This meant staff may not be sure of people's individual needs.

● Staff told us they did not have time to read people's care plans and care plans were not kept up to date. One staff member said, "We don't read the care plans because we don't have time." Another staff member said, "Staff don't have time to review or complete care records."

Staff did not have the information and time required to achieve people's preferences and ensure their needs were met. This is a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Person-centred care.

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.

● The manager understood their responsibility to comply with the Accessible Information Standard and could provide information about the service in different formats to meet people's diverse needs.

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

● We saw evidence of activities taking place and people engaging with them.

● Relatives told us they felt welcome when the visited and staff responded well to them

● A person told us, "I am a reader so [staff name] gets me books from the charity shop."

● A relative told us, "The activity staff are really good and engage people, but when they are not here the staff don't have time to stimulate people."

Improving care quality in response to complaints or concerns

● People and relatives told us they knew how to make a complaint. A relative told us, "If I have a problem I would only speak to the manager, then I know things would be sorted."

● There were procedures in place for making compliments and complaints about the service. This included details of the Local Government Ombudsman (LGO) so complainants could escalate their concerns if they were dissatisfied with the outcome of any investigation by the provider. We looked at how a recent complaint had been managed. We saw it had been thoroughly investigated and a written response was provided to the complainant.

End of life care and support

● At the time of the inspection, no one was receiving end of life care.

● Some people had basic end of life care plan in place. However, one person who was admitted to the home for palliative care, had no end of life care plan in place. This meant their preferences and wishes for their care and treatment at the end of their life had not been considered.

● People had conflicting information in their care plans regarding end of life and resuscitation wishes. Three people had 'do not attempt cardiopulmonary resuscitation order' (DNACPRs). However, their care plans stated they wanted 'active treatment'.

We recommend the provider considers best practise guidance in relation to documenting peoples end of life wishes.

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 good. 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

- The provider did not have adequate systems in place to make sure people received person-centred care.
- People's care plans did not reflect all of their preferences, wishes and needs.
- Staff did not have all the information they required to provide safe care.
- The provider did not have sufficient systems in place to identify when support and care was not delivered in line with best practice, which means there was a risk unsafe care would go unrecognised
- We found numerous risks to people. For example, there was a risk, people may not be able to summon support when they needed it. During the inspection the call bell monitor had been turned off at the wall.
- People were at risk of not receiving safe care. The provider did not have systems in place to make sure all risks had been assessed, monitored and mitigated. .
- Staff were not provided with clear guidelines on how to support people. For example, staff were supporting people with catheter care, but there were no risk assessments or care plans in place around safe catheter care.
- The provider did not always ensure people's daily notes were kept securely or understand the importance of having detailed records.
- Quality assurance systems and processes were ineffective. They did not identify gaps in people's care records, medicines errors, people's weight loss, low stock and poor record keeping. This meant they did not identify where care standards fell short of those required to put actions in place to reduce risks to people.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The provider had not offered regular meetings to staff, people or relatives and had not engaged people or staff to feedback on the quality of the service. This meant that the provider did not have the information to improve the quality of care.
- People's relatives told us they were kept up to date if any changes occurred to their relatives.
- People and staff told us the manager was visible within the service and they could access them if needed.

People were placed at risk of harm as adequate systems and processes were not in place to assess, monitor

and improve the quality and safety of the care provided. The provider failed to keep people's confidential data secure. These are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Good governance.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The manager told us they understood, and would act on, their duty of candour responsibility.

Continuous learning and improving care. Working in partnership with others

● The management team worked in partnership with other health and social care professionals and commissioners.

● The manager told us that they meet with other home managers and gain support from the provider to keep their knowledge up to date.

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 The provider failed to ensure all the necessary information was recorded to meet people's needs. The provider failed to ensure that people who use their service received person centred care and treatment that is appropriate, meets their needs and reflects their personal preferences. The provider did not design care with a view to achieve people's preferences and ensure their needs were met.

The enforcement action we took:

We imposed conditions requiring monthly action plans demonstrating how they are to achieve and maintain compliance with the regulations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider did not ensure people were not always treated with dignity and respect.

The enforcement action we took:

We imposed conditions requiring monthly action plans demonstrating how they are to achieve and maintain compliance with the regulations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure people's risks were being assessed and managed appropriately. The provider failed to ensure proper and safe management of medicines. The provider failed to ensure procedures relating to infection control had been followed. The provider failed to ensure that incidents affecting people were reviewed, investigated and monitored.

	The provider failed to assess and plan for the delivery of safe care.

The enforcement action we took:

We imposed conditions on the registration to restrict admissions to the home and we also imposed conditions requiring monthly action plans demonstrating how they are to achieve and maintain compliance with the regulations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to have suitable systems in place to protect people from potential abuse or improper treatment.

The enforcement action we took:

We imposed conditions requiring monthly action plans demonstrating how they are to achieve and maintain compliance with the regulations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider failed to meet the food and fluid needs of people.

The enforcement action we took:

We imposed conditions on the registration to restrict admissions to the home and we also imposed conditions requiring monthly action plans demonstrating how they are to achieve and maintain compliance with the regulations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider failed to ensure equipment was located correctly and properly maintained.

The enforcement action we took:

We imposed conditions requiring monthly action plans demonstrating how they are to achieve and maintain compliance with the regulations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to have adequate systems in place to monitor the quality care being provided. The provider failed to keep people's confidential

data secure.

The enforcement action we took:

We imposed conditions requiring monthly action plans demonstrating how they are to achieve and maintain compliance with the regulations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to ensure all staff had undergone the relevant recruitment checks and had the skills and competencies to provide safe care.

The enforcement action we took:

We imposed conditions requiring monthly action plans demonstrating how they are to achieve and maintain compliance with the regulations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure there were enough numbers of care staff deployed to meet peoples assessed care and support needs.

The enforcement action we took:

We imposed conditions on the registration to restrict admissions to the home and we also imposed conditions requiring monthly action plans demonstrating how they are to achieve and maintain compliance with the regulations.