West Villa Residential Home Limited

West Villa Residential Home

Inspection report

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Wakefield
West Yorkshire
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
West Villa is a residential care home providing personal care to 29 people aged 65 and over at the time of the inspection. The service can support up to 32 people.

The home is over three floors, with communal living spaces on the first floor. People's bedrooms are on all three floors.

People's experience of using this service and what we found
People's care was not provided safely. Individual risks to people and risks within the premises were not identified, mitigated or monitored. People who required support with moving and handling did not have individual equipment and no assessments had been carried out to ensure equipment was safe for them to use. Medicines were not managed safely, which put people at risk of harm. Fire safety was not given high priority and people's individual emergency evacuation plans were not accurate. Recruitment processes were not always robust and there were insufficient numbers of suitability trained staff, especially at night. Accidents and incidents were not monitored and safeguarding procedures were not always followed.

People's needs and choices were not assessed thoroughly. There were poor systems in place to support staff to provide effective care. Staff did not have appraisal or consistent supervision and there were no competency checks to make sue they had the right knowledge and skills to meet people's needs. Consent to care and support was not consistently obtained, monitored or reviewed in line with legal requirements and national guidance.

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.

Care and care documentation was not person-centred. Activities took place but some people were bored and at risk of social isolation.

Management systems were weak and there was a lack of oversight of the quality of service delivery. Audits were being done but they lacked rigour and had not successfully addressed the breaches since the last inspection. There were gaps in actions, dates and signatures. Accidents and incidents were not always reported to CQC as required.

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

Rating at last inspection and update
The last rating for this service was Requires Improvement (published 14 August 2018).

We found four breaches of regulations relating to safe care and treatment, need for consent, good governance and fit and proper persons employed.

At this inspection not enough improvement had been made and the provider was still in breach of these regulations. We identified four further breaches of regulations relating to person-centred care, safeguarding service users from abuse and improper treatment, premises and equipment and staffing.

Why we inspected
This was a planned inspection based on the previous rating and to follow up on action we told the provider to take at the last inspection.

The inspection was prompted in part due to concerns received about staffing and safe care and treatment. A decision was made for us to inspect and examine those risks.
The overall rating for the service has changed from Requires improvement to Inadequate. This is based on the findings at this inspection.
We have found evidence that the provider needs to make improvement. Please see all sections of this full report.

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

Enforcement
We have identified eight breaches in relation to: safe care and treatment; need for consent; good governance; fit and proper persons employed; person-centred care; safeguarding service users from abuse and improper treatment; premises and equipment; and staffing at this inspection.

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

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

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

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

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?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not 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.

West Villa Residential 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 was carried out on the first day by two inspectors, a specialist professional advisor in medicines and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. There were two inspectors on the second day of the inspection.

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

This inspection was unannounced on both days.

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

During the inspection
We spoke with 11 people who used the service and four relatives about their experience of the care

provided. We spoke with the registered manager, the deputy manager, four care staff, the cleaning staff, two cooks and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We reviewed a range of records. These included five people's care records, 15 people's medicine records, four staff files in relation to recruitment, training and supervision. We looked at a variety of records relating to the management of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training information, policies and procedures and records of safety checks. We made referrals to Environmental Health and the Fire officer due to concerns about people's safety with regard to premises and equipment.

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.

Assessing risk, safety monitoring and management
At the last inspection the provider was not taking sufficient action to assess, identify or manage risks. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, not enough action had been taken to ensure risks to people were identified and managed, which meant there was still a breach of regulation 12 and people were at continued risk of significant harm.

- There was little evidence premises and equipment were rigorously checked or managed to ensure people stayed safe. For example, the gas safety certificate expired in January 2019 and there was no legionella certificate. We found a warning notice issued by a gas safe engineer in March 2019, which stated the gas cooker was dangerous and must not be used. This had been in continuous use since that date, despite the warning and no action had been taken to ensure people's safety. We saw a fire risk assessment which had been carried out by an external company in May 2019, but there was little evidence of any action taken to address the recommendations made. We made an urgent referral to the local authority environmental health and the fire officer, who visited the service the following day. We spoke with both the fire officer and the senior environmental health officer following their visits. The senior environmental health officer issued a legal notice in relation to the gas cooker. The service had made temporary alternative cooking facilities and was in the process of sourcing a permanent solution. The fire officer said he had no urgent concerns, but would be following up on fire safety issues at the home the following day.
- Some lifting equipment had been checked as required, but there was no evidence each lifting sling had been checked for safety. One person was moved using a sling which was soiled and labelled for another person, and staff were unable to show us any suitable alternative equipment for this person.
- The registered manager told us there was some refurbishment identified and said floor covering was to be replaced where it was worn, stained or caused a trip hazard. On the second day of the inspection there were two communal areas where the floor covering had been removed, leaving the sharp carpet grippers exposed and hazardous. The registered manager attempted to cover these with sellotape but the sharp grippers poked straight through. There had been no risk assessment carried out for the work and although the floor fitters came the same day, this caused hazards that had not been mitigated.

Concerns about the safety of premises and equipment meant there was a breach of Regulation 15 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and there was a continued breach of regulation 12

- Risks to people had not been consistently identified, assessed or mitigated. One person had been visited

by the nominated individual to assess their suitability to live at the home on 3 July 2019. The pre-admission assessment had not been fully completed. For example, information had not been added for questions such as, 'is the person responding to this questionnaire?' 'does the person have any cultural requirements?' 'does the person require any current nursing interventions' and 'is any equipment required'. The person was admitted to the home on 6 July 2019. We looked at their care plan and found no further information had been added. Where it was identified the person's well-being was at risk, no risk assessments were in place, for example those covering risk of falls, moving and handling and infection.

● Another person's pre-admission assessment was blank in many places and there was no care plan or assessment of risk completed even though the person had some risks associated with their care.

● Risk assessments were not always completed where people's care needed close monitoring, such as for pressure relief or the risk of choking.

● Staff did not always know people's needs or how to support them safely. One person required a high level of personal care and support. One staff member told us, "I don't feel we know a lot about [name] they're not able to tell us about themselves and there has been very little family contact." Another staff member said, "[Name] is being cared for mostly in bed at present because [they are] not well, and we are waiting for some further equipment, so they can be moved easily for example, a positioning chair and a wheelchair." Staff were not clear about the person's current moving and handling needs and could not tell us how this was done.

● We saw there was a PEEP (Personal Emergency Evacuation Plan) in place for one person. The PEEP did not accurately reflect the support the person needed in the event of an emergency as it stated the person could walk to a place of safety, with one carer and no equipment was needed. This was not correct as the person required support from two staff and a wheelchair for moving around. The service had failed to accurately assess, manage and mitigate risks to people which placed them at risk of harm.

● Staff were not clear about people's moving and handling needs and we were told conflicting information about how many people needed hoisting equipment. This information ranged from three people to seven people. Where people's care records showed they needed to use a hoist, there was no detail about the type of sling to be used or how this had been assessed properly on an individual basis. We saw stark contrasts in how people were moved and handled using equipment. One person was supported appropriately and with reassurance about using the hoist and sling. However, we saw a very dangerous incident in which a person was moved unsafely and placed in a seat which they immediately slipped downwards in. We intervened as we were very concerned the person would fall from this seat and we brought this to the attention of the registered manager.

● There was limited investigation into accidents and incidents and monitoring of these was poor and did not support opportunities to learn or prevent reoccurrence.

● We received mixed feedback from people about whether they felt safe. Some people said they did feel safe and comments included, "I feel one hundred percent safe, no concerns", "I have no worries it has been great here and safe", "I feel safe so far, you know there are people around. I have no worries about the staff" and "I feel safe with no worries". Yet other people said they did not feel safe and comments included, "I do not feel safe as a man pushed me down. I reported it to the manager but I don't feel safe now" and "There is not enough staff, too many chiefs and not enough Indians."

Systems and processes to safeguard people from the risk of abuse

● Safeguarding systems were not robustly in place to ensure people were protected from abuse and harm. Staff were not always aware of incidents which may need referral to the local authority safeguarding teams. Referrals were not made promptly and although there was a log of safeguarding incidents, this was not complete.

● The safeguarding procedure was sent to us following the inspection. This was dated August 2019, referred to out of date guidance and signposted staff to the home manager or the nominated individual. Telephone

numbers for staff to make referrals to external agencies were not available.
People were not protected from abuse or harm and we asked the provider to make safeguarding referrals for two incidents which resulted in injuries to people. This was a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
At our last inspection, the provider was unable to demonstrate they consistently followed safe recruitment procedures. This was a breach of Regulation 19 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 still in breach of regulation 19.
●In the main pre-employment checks had been carried out before staff started work, such as criminal record checks and references. However, we found one staff member who was working with a POVA (Protection of Vulnerable Adults) first check only as their full Disclosure and Barring Service (DBS) check had not arrived. The provider told us their policy was that staff could work on a POVA first check but must be under the constant supervision of other staff. We found the staff member had worked on nights with one other staff member, which meant it would not have been possible for the person to be under constant supervision. Confirmation of the member of staff's DBS was sent to CQC and this had been completed before the second day of the inspection.
● In another staff file, we saw although the staff member had given a full employment history, they had not given their last employer as a referee and their last employer was not contacted to provide a reference. This meant people were not always protected from the risk of being cared for by staff who were unsuitable to work in the care setting.
●There were 29 people using the service. The registered manager told us care staff numbers were five in a morning, four in the evening and three during the night. This was the number of staff needed when dependency levels were assessed.
● The registered manager told us the night prior to the inspection there had only been two staff on duty as one had phoned in sick. Neither of the two staff who had worked the night shift were trained in medicine administration. The registered manager said they had been on call and gone into the home at 5am that morning to assist with care and to provide any required medicines. However, there was no evidence the registered manager had up to date training or competency checks to do this. The registered manager confirmed to us following the inspection none of their own training had been completed until after the inspection.
● We looked at the staff rota from 7 July 2019 to 3 August 2019 and found nine night shifts where there were only two staff allocated on duty. The provider showed us evidence to confirm an agency staff had also worked on four of these shifts. We also found 16 shifts when morning staff was reduced to four and five afternoon shifts when staffing was three.
● Staff told us when numbers dropped below those agreed it was very difficult to meet people's needs in a timely way.
● One person we spoke with said, "They never come, I call them and they just walk past me, they're always busy with other stuff." Another person said, "I usually see staff on and off through the day. They come to my room sometimes and ask if I need anything. I try not to call for them as I know they have a lot to do."
The provider confirmed to us they would increase staffing levels at night with immediate effect and we saw by day two of the inspection, this had happened.
Systems were not in place or robust to ensure sufficient numbers of suitably trained and competent staff were deployed to meet people's needs safely. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
There was a continuing breach of regulation 19.

Using medicines safely

● Medicines were not managed safely. The provider's policy and procedure was out of date, did not refer to relevant professional guidelines and made reference to domiciliary care, not care homes. The provider agreed to review this and had taken some steps to do so following the first day of the inspection.

● Staff responsible for supporting people with medicines did not all have recent or up to date training and competency checks for this.

● There was little evidence to show people always received their medicines on time, as prescribed and as they needed them. For example, for one person, who was prescribed a time-critical medicine, their care plan stated they needed their medicine at key times 8am, 12pm and 4pm, yet this was given at 9.30am and had not been given again until 2pm. Another person, had cream which was unopened in a new box, yet staff had signed to say there had been three applications. Another person had eardrops prescribed one drop once daily to both ears, yet these were being applied twice daily. A further person was prescribed regular lorazepam six-hourly, yet we saw this was noted on their PRN (as required) protocol to be given every hours. For one person, their inhaler was incorrectly given and there was poor recording around this.

● Recording of medicines was inconsistent; cream charts did not show staff where to apply and body maps were not consistently in use. Disposal of medicines returned to the pharmacy were not always logged. Dates when medicines were opened and to be used by were not recorded. PRN protocols were not consistently recorded or used. Care plans for people's medicines were not always accurately recorded or dated. One person's medicine record did not have their allergy status clearly noted.

● Furthermore, the clinic room did not have good ventilation to ensure clinic room temperatures were below 25 degrees to safeguard the integrity and stability of the medicines. On the day of the inspection, the temperature surpassed 25 degrees.

Systems were not in place or robust to ensure medicines were managed safely. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● There was continuous cleaning taking place during the inspection and we spoke with cleaning staff who understood their role. Some fixtures and fittings were in need of replacement and the registered manager told us there was refurbishment ongoing throughout the home. We saw where carpet was stained this was removed and replaced with washable flooring.

● Staff were seen to use protective gloves and aprons to minimise the spread of infection.

● People and relatives said they thought the home was suitably clean.

Learning lessons when things go wrong

● There was limited opportunity to identify where lessons could be learned, such as through accidents and incidents. For example, where staff identified an unexplained injury there was no evidence of any exploration into how this may have happened and what could be done to prevent a reoccurrence.

● There had not been sufficient attention to address the issues identified at the last inspection or to prevent further breaches in the regulations.

Inadequate

Is the service effective?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate.

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

Staff support: induction, training, skills and experience

- Staff told us most of their training was completed on-line. Training in moving and handling, first aid and fire was classroom based.
- The provider and staff told us they were required to update their mandatory training each year. However, the training matrix showed some staff had not completed their training within the agreed timescale. For example, one staff member had not completed updates for 12 of the 16 mandatory training courses and another staff member had not completed 10 of the 16. Of the 25 staff listed, 12 had not completed all their required training.
- We asked for the registered manager's training record following the inspection. They sent us information to show they had completed some training following the inspection, on 3 and 4 August 2019. They confirmed to us on the telephone they had not completed any such training prior to this whilst working for the provider, although said they had done training within their previous employment.
- There was no evidence to show staff competency had been checked to make sure they supported people effectively.
- The provider's supervision policy stated staff would be provided with a minimum of four supervisions per year, of which two must be one to one and others could be either a group supervision or a competency observation. However, the supervision matrix showed some staff had not received any supervision from January 2019 until July 2019.
- None of the staff spoken with were aware of how many supervision sessions they had or should have had. However, they said they could go to the managers informally at any time and ask for their advice and guidance.
- Staff spoken with said they could not remember completing an appraisal. The registered manager confirmed to us that no staff appraisals had been completed since they had been in post as the manager in May 2018.

Suitably trained and competent staff were not deployed to meet people's needs. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- People's needs and choices were not thoroughly assessed. Pre-admission information was blank in some of the records we looked at and there were missing assessments of risk and guidance for staff to support

people effectively. Care plans did not illustrate how people's choices and preferences were promoted in their care and support.

Supporting people to eat and drink enough to maintain a balanced diet
● People told us they enjoyed the meals overall. Comments included, "The food is alright and if I wanted something different they would get it for me", "It is a good Sunday dinner", "Yes I like the food", "There is not enough choice of food" and "Some of the food is okay, some is not."
● Staff said they knew which people needed support with their meals and who was at risk of losing weight. People were supported by staff to have their meals where they needed help with this. Plate guards were used if people needed these. The meal tables were laid with cloths, mats and cutlery and people were offered a choice of drinks.
● We spoke with two cooks, who told us they understood people's dietary needs and there was a record of these in the kitchen.
● There were drinks accessible and within view for people and staff reminded people to drink during the very warm weather. On the second day of the inspection, we arrived around 7am and some people said they were thirsty. There was little evidence they had been offered a drink upon waking and some people said they had not had anything, despite being awake a long time. The registered manager responded when we brought this to their attention and helped prepare drinks for people.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● There was some evidence of staff involving other professionals in people's care, such as district nurses, dieticians, speech and language therapists and GPs. However, where staff told us some people had been referred to memory services and for equipment assessments, there was no evidence to support this. There was no evidence to show people had been involved in making decisions about their own health care.
● People and relatives were confident staff would seek relevant professional advice and support if needed.

Adapting service, design, decoration to meet people's needs
● Some people told us they knew about changes to the environment, such as the new floor surface being installed on the second day of the inspection. However, some people said they had not been informed. One person said, "They told me I'm sitting in here and I can't go in there (lounge) but I don't know what's happening.

Ensuring consent to care and treatment in line with law and guidance
At the last inspection there was a breach of the Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because there was no information to show if Lasting Power of Attorney (LPA) orders were in place. A LPA is a legal document that allows someone to make decisions for you, or act on your behalf, if you are no longer able to or if you no longer want to make your own decisions. LPA's can be put in place for property and finance or health and care. If these are not in place the 'best interest' process needs to be followed to support the decision making process. At this inspection this information had not been obtained and there was still a breach of regulation 11.

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.

●There was a lack of understanding about the legislation and guidance around consent and staff did not uphold people's rights.
● Consent to care was not consistently sought and people's capacity to make decisions was not adequately assessed. Where people were said to have capacity, there was a lack of consent detailed in their care records, documentation was blank where signatures were not obtained. Where people's capacity was in question, there were no relevant formal decision specific-capacity assessments or any best interest discussions/decisions carried out. Some capacity and best interest discussions were recorded from 2018, but there had been nothing detailed since.
● People were not supported in the least restrictive way possible. Locks were on people's doors and staff told us all bedroom doors were locked at night. The registered manager told us there were master keys accessible centrally on each floor so staff could gain access to support people in their rooms. However, when we spoke with staff, not all staff knew where there was a key. There was no consent obtained from people for them to have their doors locked at night. Not all people in their rooms were able to exit independently from their room. Some people had sensor alarms in their rooms, and some people had bedrails, yet there was no consent sought or best interest decisions recorded.
● Systems for ensuring DoLS were poor and there was no management oversight of how many people had these in place or whether there were any conditions to these. Some people's DoLS had expired and there was no evidence of these being followed up.

This meant there was a continued breach of regulation 11.

Inadequate

Is the service caring?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate.

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

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

- People were not always involved in decisions about their care and staff did not always understand where people needed help from others. For example, one person clearly stated they wanted to move to another home and told us they had raised this with the provider. There was no evidence any support had been put in place to help this person make an informed decision, or offer advocacy and information. We asked the registered manager to make an immediate review of this person's care and take their views on board.
- Where some people had difficulty expressing their views verbally, staff lacked understanding about how to communicate effectively with them. For example, where people presented with behaviours that challenged, staff responded by giving people time to 'calm down' in their room, but with no follow up action to establish the root cause of the behaviours or what the person may be trying to communicate.

Respecting and promoting people's privacy, dignity and independence

- Some people were left with food stains on their clothes all day, their hair was greasy and their personal hygiene needed attention. One person had very dirty fingernails and their mouth was visibly dirty. We asked staff about oral hygiene support for the person and they said this was carried out daily. However, the person in question did not have a toothbrush in their room. Staff took action the same day and attended to the person's oral hygiene needs. Another person told us staff helped them brush their teeth 'now and again'. The registered manager told us a member of staff had been appointed oral care champion.
- Some people we spoke with said staff supported them well with their independence and personal care needs. Comments included, "They respect my independence and I can have a bath whenever I want", "They help me move around even though I'm slow", "I am not as independent as I was as I have had a few falls. I have a bath once a week and get washed every day" and "They completely respect my privacy and my independence."
- Relatives told us they felt welcome to visit their family members at any time. Visitors were greeted in a friendly way by staff. One person's visitor told us, "I just come when I like, they know how important it is for [person] to have visitors." Another person's relative told us staff brought their family member to visit them in hospital.
- Information was not always managed to promote people's privacy. For example, staff said they opened people's mail if they thought it was related to a health appointment. One person had been offered one to one counselling sessions with an activities coordinator but there were no records available about this because the member of staff had taken these away with them when they left their employment. The

nominated individual agreed they would try to retrieve these.

People were not sufficiently involved and included in their care and this was a breach of the Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Despite the concerns identified during the inspection, staff did their best overall, and as much as they were able to influence, to make sure people were cared for.
- Staff mostly had a kind and caring approach and a good rapport with people, and knew about some people's personal histories. However, on one occasion we heard a member of staff speak in a sharp tone with a person who had spilled a drink.
- Most people told us staff were patient and friendly. Comments included, "The staff are okay", "The staff are brilliant. They keep a check on us and sit and talk to me", "They do give me encouragement", "The staff are alright, they treat me with respect and dignity" and "The staff are kind and caring." However, not everyone spoke positively about staff attitude; one person said, "Some staff are kind some are not."

Inadequate

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate.

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

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

- Care was not personalised to meet people's preferences. People were not involved in their care plans and care planning was not focused on individual risks, goals, skills and abilities. The same phrases were repeated across care plans, which meant they were not written in an individual way. Language used in care plans and other records about people's care was not person-centred. For example, handover notes stated 'all residents must be toileted before lunch' which suggested a lack of individualised care and support. Some care plans lacked information and guidance for staff which was critical to people's safe care and support.
- People and relatives did not always know there was a care plan, and when they did they said they were not really kept informed about what was in it. Comments included, "I did not know I had a care plan", "My family deals with my care plan. They never discuss my plan with me. And I am not allowed to look at it" and "I presume there are records kept about [my family member] but nobody has told me and I'm sure [my family member] has not been involved."
- There was no adequate review system in place to ensure care was responsive to people's needs. Where records about people's care showed concerns, such as records of behaviour that challenged, there was no follow up to ensure the person's needs were being met. For example, records showed one person repeatedly stated they wanted to die, yet there was no evidence of thorough monitoring of the person's well-being or referral to other professionals.

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.

- There was little evidence to show how the service had implemented ways in which people's diverse communication needs were identified, recorded and met. Where people had a disability of a sensory loss, there was no evidence their communication needs had been explored or any effort to communicate with them in ways they could understand. For example, one person had been at the home for three weeks, yet staff said they did not know how to communicate with them. There was no evidence in their care plans of how this had been attempted and the person had been cared for in their room with minimal interaction from others.

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

● There were mixed views in relation to activities. Comments included, "There is enough to do we do have some games. We went out to the coast. I enjoyed that. My family write to me and I write back", "I have been out shopping and for fish and chips, The carer took me" and "They are good to us and there is enough entertainment. I do bingo and have a chat". However, some people said they did not go out enough and they wanted to go more. They said, "To ask to go out would be like taking a bone off a dog", "I've only been out three times all year" and "I'm really bored, it makes me fed up."

● On the first day of inspection we saw people spent long periods of time in their chairs with little to do. People sat passively and there was little to occupy them. On the second day of the inspection the activities staff invited people to join in with some activities, but these were not always reflective of their personal hobbies or interests. Children from the local school and nursery visited the home to take part in activities with people.

● Some people spent long periods of time in their rooms. Where they were able to talk to us, they said this was their choice. However, staff told us one person was in their room because they were waiting for some specialist equipment so they could be transferred downstairs during the day. There was nothing in the person's care record to show how they were being prevented from social isolation or loneliness.

Care was not person-centred and this was a breach of the Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

● Some people and their relatives said they knew how to make a complaint, whilst others said they did not know. People said they would let staff know if they had any concerns.

● There were some records of complaints received from people who used the service, for example, about the meals service. There was evidence people's concerns had been listened to and acted upon and these were documented appropriately.

End of life care and support

● There was mixed information about people's end of life wishes in care records. The registered manager showed us a letter from a Macmillan nurse which gave praise for the way staff had provided end of life care for a person.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate.

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care
At the last inspection there was a breach of the Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because there was a lack of robust quality assurance. At this inspection, previous regulatory breaches were not actioned and new breaches had occurred. The lack of consistent and effective leadership and robust quality assurance meant people were at risk of receiving poor quality care and there was still a breach of regulation 17.

- The service has a history of regulatory breaches and has had several managers in post.
- Systems and processes did not drive forward improvement. Not enough action had been taken to prioritise concerns identified at the last inspection or meet the requirements of the warning notices. Furthermore, new breaches in regulations were found at this inspection.
- There was a lack of understanding of best practice guidance, legal requirements and oversight of risks to people's safe care and treatment; staff were not adequately trained or supported, known risks were ignored and new risks were not identified or mitigated. Incidents were not appropriately reported.
- Quality management systems were not effective at addressing issues raised and provider oversight of the service was poor. For example, quality audits did not identify weaknesses in medicines management, missing/ inaccurate information in care plans or serious safety concerns with premises and equipment. Action to introduce improvements was reactive
- Some people, staff and relatives spoke positively about the registered manager and said they were regularly present and involved in people's care. However, not all people or relatives knew who the registered manager was. Comments included, "I am not sure who the manager is", "It is reasonably well organised", "Yes I know who the manager is", "It is getting more organised, it used to be better", "It is well organised but not at lunch time", "It is well organised", "It is well run to my way of thinking", "It is well run considering" and "If I could change anything it would be everything."
- The registered manager said they were very well supported by the provider and said they had regular time together in the home. However, there was no evidence of the registered manager having completed any training or induction, or ongoing professional development to support them in their role. Although there was evidence the provider was regularly in the home, there was a lack of robust oversight of how the home

was managed.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- Recent surveys had been returned, which showed mixed views about the quality of the service. The registered manager told us they had not had time to review or respond to these.
- There was no systematic approach to working with other organisations to improve care outcomes.

This meant there was a continuing breach of regulation 17.