St Martin's Residential Homes Ltd

The Leys

Inspection report

63 Booth Rise
Boothville
Northampton
Northamptonshire
NN3 6HP

Tel: 01604642030
Website: www.midlandscare.co.uk

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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
The Leys is a residential home providing care and support for older people and people with dementia. The service is registered to provide personal care to up to 33 people. At the time of inspection, they were supporting 26 people.

People's experience of using this service and what we found
The leadership and the management of the service had not made enough improvements to the safety and governance of the service since the last inspection.

There was a continued lack of understanding, oversight and governance systems to ensure people received a safe service. Systems that were in place were not implemented effectively and audits did not identify ongoing concerns with the service.

Records relating to people's risks and care needs were incomplete and contained misleading information. As a result, staff did not receive all the information and guidance they required to provide care that met people's needs. People's care needs were not regularly reviewed.

Some aspects of environmental safety were not effectively managed. Insufficient fire safety measures were in place and some areas of the home were not clean or maintained in a way to mitigate infection risks.

We found there to be insufficient numbers of staff working at the service to keep people safe. People were at risk of experiencing unsafe care and treatment as a result. Staff were safely recruited.

People's nutritional needs were not properly assessed, and people did not receive the support they needed with eating and drinking. This put people at risk of malnutrition.

Improvements were required to staff training. Staff had not received all the training they required, and reliable records were not kept of staff training.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests. However, the policies and systems in the service did not support this practice.

A complaints procedure was in place and written complaints had been investigated by the registered manager. However, problems raised verbally were not always recorded as complaints, and therefore weren't dealt with in accordance with the provider's policy.

People did not always receive timely support to meet their ongoing health needs and health monitoring. People were supported to access relevant health and social care professionals when they were unwell.

We found individual staff to be caring and compassionate towards people. However, due to staffing levels at the service they lacked opportunities to spend time with people. Care being delivered was often task focussed.

People received their medicines as prescribed and staff understood their roles and responsibilities to safeguard people from the risk of harm.

We have identified breaches in relation to the management of risks to people, meeting people's eating and drinking needs, staffing levels, staff training and the governance of the service at this inspection.

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 requires improvement (29 December 2018) and the provider was in breach of one regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
This was a planned inspection.

Enforcement
We have imposed conditions on the provider's registration, for more information please see the end of the report.

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

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

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration. For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate

The Leys

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 by one Inspector, an Assistant Inspector 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.

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

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

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the service registered and sought feedback from the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

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 used all of this information to plan our inspection.

During the inspection
During the inspection process we spoke with 10 people who lived in the home and four people's relatives, we also spoke with a health care professional who was visiting the home. We spoke with 11 members of staff, including care staff, senior care staff, kitchen staff, domestic staff, the registered manager, operations manager and nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at multiple records about people's care needs and medicine needs and four staff recruitment records. We looked at other information related to the running of and the quality of the service. This included quality assurance audits, quality surveys, training information for staff and arrangements in place for managing complaints.

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

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 we found that risks to people had not always been identified and managed safely. At this inspection we found people continued to not receive care that ensured their safety. We found that action to minimise risks to people's health and wellbeing had not always been taken and this put people at risk of harm.

● Where people had been identified of being at risk of choking, we found that the care provided did not protect people from the risk of choking on their food. For example, one person's care plan identified they had complex needs in relation to eating and drinking and were at risk of choking. During the inspection we saw that staff had not sat the person up sufficiently to eat their meal. Due to staff not recognising the risks and not supporting the person into a safe position to eat and drink there was a risk they would choke.

● People did not receive the support they required to mitigate their risk of falls. One person's relative said, "My [family member] has had a number of falls. I was worried about the number of falls, but no one has spoken to us in depth about them." One person's falls assessment recorded they were at high risk of falls. The person had a falls sensor mat in place, during the inspection we saw this was broken, however staff had not reported this or taken action to mitigate the increased risk to the person.

● One person required support from staff to mobilise and their falls assessment recorded their abilities fluctuated. However, they had no manual handling assessment, falls or mobility care plan in place. And their falls assessment had not been reviewed since July 2019. Following one fall, staff recorded the person should be observed hourly, there was no record of these hourly checks taking place.

● Where people had been identified of being at risk of pressure sores, we found the care and treatment being provided did not protect people from the risk of developing pressure areas. We saw one person was at high risk of pressure ulcers; however, their pressure area assessment had not been reviewed since July 2019. They had had a previous pressure ulcer and staff had recorded in care notes they were to be supported to reposition every two hours. A review of repositioning records showed this was not followed by staff. For example, on one occasion there was no record of the person being supported to reposition for six and a half hours. The person required their pressure relieving mattress to be set to their weight, we saw the weight control was taped in place at the wrong setting. There was an increased risk the person's skin would break down due to ineffective skin care.

● Insufficient fire safety measures were in place. Fire exits in part of the building were not labelled. There was a risk that people, visitors and staff would not be able to safely evacuate in the event of a fire. The door releases on the fire exits to be used in the event of a fire were too high for some staff to reach. There was a risk that staff would be unable to open the doors to enable people and staff to evacuate.

Preventing and controlling infection

● Some areas of the home were not clean or maintained in a way to mitigate infection risks. One person's relative told us a dirty incontinence pad had been left in their relatives ensuite toilet for several days. There was a strong odour in two people's bedrooms and one of the communal bathrooms contained dirty equipment.
● The procedures in place to manage people's laundry were not effective. The area where soiled laundry was washed was dirty and cluttered. The area where clean laundry was ironed contained dirty equipment.
● Food hygiene procedures were not consistently followed. We saw catering staff working in the kitchen without suitable personal protective clothing. Care staff were also working in the kitchen after providing people's personal care without putting any personal protective clothing on.

Systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● There were not enough staff deployed to meet people's needs. One person said, "They are always rushing about, and I think it takes too long for me to get help." Another said, "It sometimes takes ages to get some help, but I try to be patient."
● We found there were insufficient staff, particularly on night shifts. The required number of staff overnight was three but on a number of night shifts only two staff were deployed. We discussed this with the registered manager and provider who explained this was due to staff vacancies and sickness; they told us they would ensure enough staff were deployed every night going forwards.
● There were insufficient staff to monitor and safely manage risks posed by people's behaviour. During the inspection we saw people were showing signs of distressed behaviour and there were no staff present to offer support to them or other people who were impacted.
● People's meal time experience was poor due to a lack of staff. We saw people received cold food as there were not enough staff to serve their meal. Some people who required help to eat did not receive timely support as staff were busy helping others.

Systems were either not in place or robust enough to demonstrate staffing levels were effectively managed. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were safeguarded against the risk of being cared for by unsuitable staff because there were appropriate recruitment practices in place, which were consistently followed.

Learning lessons when things go wrong
● The provider had very basic systems to review the service. There had been little opportunity to learn from incidents or concerns as detailed record keeping of quality monitoring for all areas of the service was not in place.
● The registered manager had an action plan in place and was working with the local authority to make improvements to the service.

Systems and processes to safeguard people from the risk of abuse
● Staff knew how to recognise and report any concerns about poor care or ill treatment and had confidence that senior staff would take appropriate action. One member of staff said, "I would report any concerns to a senior, or to the manager."
● Records showed that not all staff had received training in safeguarding. However, staff told us

safeguarding people from abuse was discussed with them during their induction.
● The registered manager was aware of their responsibilities for making safeguarding referrals and the requirement to notify the CQC.

Using medicines safely
● Prior to the inspection the registered manager had recognised that medicines procedures could be improved and had been working with the 'care homes advice pharmacy service' and staff to improve medicines practices in the home.
● Medicines systems were organised, and people were receiving their medicines as prescribed. People's medicines were stored safely, and processes were in place for the ordering and supply of medicines. Staff completed people's Medication Administration Records, to confirm people had taken their medicine.
● The registered manager carried out regular medicines audits to ensure that any concerns were promptly identified.

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 Requires Improvement: This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

● People were at risk from malnutrition and did not receive the support they needed with eating and drinking. We saw two people who had their lunch served in their bedrooms and were not able to eat independently. Staff were not available to provide support or encouragement and their food was left to go cold. One person told us, "Lunch was cold but by the time they [staff] came back to my room I'd gone off it. Too many sandwiches and always toast at breakfast."

● We saw one person was experiencing significant difficulties eating independently. There was no care plan for staff to follow to ensure they received the support they needed, and referrals had not been made to appropriate medical professionals. The person had lost a significant amount of weight.

● Another person was identified as being at high risk of malnutrition, however their risk of malnutrition had not been assessed since June 2019. The person's care records stated they should be weighed weekly, but this was not being carried out.

Systems were either not in place or robust enough to demonstrate people's nutritional needs were effectively managed. This placed people at risk of harm. This was a breach of regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Views about the food were mixed. One person said, "The food is not a problem, some choice but not always. I'm always hungry so have seconds." Another person told us, "It really depends on who the cook is, there's been lots of changes lately."

Staff support: induction, training, skills and experience

● The provider had not ensured that staff working at The Leys had received the training required to enable them to effectively carry out their role. A new care assistant who was working unsupervised in the home told us that other than manual handling training and a general introduction to the requirements of their role they had received no training.

● Senior management had recently identified in an audit that although the training matrix showed staff had completed training, many staff had no certificates to evidence the training. The provider did not know whether staff had completed their training or not. The required training had recently been re allocated to staff and was in progress at the time of inspection.

We found no evidence that people had been harmed however, systems were either not in place or robust

enough to demonstrate staff training was effectively managed. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had not always received supervision and appraisal in line with the provider's policy, although the registered manager had recently increased the frequency of supervision for staff. Staff spoke positively about the support that was available to them. One member of staff said, "I love it here, we definitely get support and I've never had to do anything on my own I'm not comfortable with."

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.

● We found there had been a lack of oversight of people's Deprivation of Liberty (DoLS) applications. As a result, five people's authorisations had expired and there had been a delay before a new authorisation was requested. At the time of inspection all required applications had been made and the registered manager was waiting for these to be reviewed by the local authority, however there was a risk that people had been unlawfully deprived of their liberty.
● Mental capacity assessments had taken place where there were concerns about people's ability to make their own decisions. However, where it was deemed people lacked capacity, best interest decisions had not always been recorded.
● Mental capacity assessments and best interest decisions did not always record who had been consulted as part of the assessment and decision-making process. The registered manager was aware that this was an area where development was required and was working with the local authority to make improvements.
● Staff knew people well and understood the need to seek people's consent when providing their support. One member of staff told us, "If people are able to, they choose what they want to do." We observed staff asking for people's consent before providing their support.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Although the areas where people required support were assessed by the registered manager, staff had not been provided with sufficient guidance to deliver people's care in line with legislation and evidence-based guidance.
● Records did not accurately reflect people's needs. People had been assessed before they started to use the service, however the care plans and risk assessments based on the information gathered were not detailed and contained inconsistent information. This put people at risk of harm.

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

● Improvements were required to ensure the environment consistently met people's needs. Newer parts of the building were adapted to the needs of people living with dementia. However, older areas lacked pictorial information and signage to help people find their way around.
● Although an improvement plan was in place, sufficient improvements had not been made to the environment in a timely manner. We saw many areas that required maintenance and redecoration, including broken radiator covers and threadbare carpets.

Supporting people to live healthier lives, access healthcare services and support. Staff working with other agencies to provide consistent, effective, timely care
● People did not always receive support to meet their health needs. The provider had not recognised the importance of oral health care and people did not have oral health assessments in place to guide staff in meeting their oral health needs. People were not supported to have regular dental check-ups.
● Staff did not always ensure people had access to regular health monitoring. For example, we saw letters from health care professionals requesting the same information across a period of several months before staff responded. This meant people were at risk of not having their health needs met.
● Staff knew people well and were vigilant to changes in their health and sought appropriate medical support. One person said, "The doctor comes out to see me if I'm not well, they change your tablets if needed."

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

- People were supported by individual staff that were kind and caring. However, people's experience of care was affected by the insufficient staffing levels in the home. One person told us, "They [staff] are trying to do their best, but they don't seem to have time to chat to me." Another person's relative said, "Generally most of the staff are good, nice girls and they are caring, but the attention to detail is not good."
- People provided positive feedback about the kindness of staff and their positive approach to their work. One person said, "The staff are fine, I like it here, they are kind." Another person said, "The staff seem to love it, even when they have to change me, it's no trouble." We observed that although staff were very busy they interacted with people in a kind, respectful and compassionate manner.
- Care plans included basic information about people's cultural preferences, values and beliefs, and any religious and spiritual needs.

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

- People were involved in making decisions about how they wanted their care and support needs to be met at their initial assessment. However, none of the people and relatives we spoke to were aware of the information contained in their care plan and none had been invited to review their care. We discussed this with the provider, who was aware that this was an area where the service needed to improve.

Respecting and promoting people's privacy, dignity and independence

- At the previous inspection we found that people's private information had not been stored securely. At this inspection we found ongoing concerns with how people's personal information was stored. We found people's care plans and records were stored in a cupboard in the entrance corridor that had a bolt on the outside which could be undone by anyone.
- Some people's relatives told us their family members were not always supported with their personal care in a way that maintained their dignity. One person's relative said, "[Family member's] hands where filthy the other day, there's not enough attention to personal care." Another relative told us, "Sometimes when we come in [family member] has food down the front of their clothes."
- People told us staff respected their privacy and right to make their own choices. One person said, "They [staff] respect my privacy and know I like to stay in my room."
- People were encouraged to be as independent as possible. One person told us, "I have freedom, I often go out and the staff discuss this with me."

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; 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

- People's risk assessments and care plans were confusing and lacked the detail needed to ensure people received consistent, personalised care. People's care plans did not provide sufficient information to guide staff in meeting their needs. For example, how to move safely, skin care, health needs and eating and drinking needs. There was a risk that people's care would not be appropriate or meet their needs.
- The registered manager recognised that care plans were not person centred and did not fully reflect people's needs. They were in the process of reviewing and re-writing all care plans, although sufficient progress had not been made. The provider told us they will ensure the registered manager has additional support to ensure this is completed in a timely manner.
- Regular reviews of people's care needs were not in place and many people's care had not been reviewed for several months.
- People told us there was a lack of activity and stimulation in the home. One person said, "There are no activities here, so I do puzzle books. I haven't been out lately. I really need something to keep my hands moving." Another person's relative said, "There's little activity or entertainment. Staff just do care; give out food, clear away and help people in their rooms."
- We saw there was very little activity available and people sat with nothing to do for long periods of time. Although a musical entertainer was performing in the lounge on one day of the inspection.
- The registered manager explained the person employed to co-ordinate activities had recently left and they were without this provision at the moment; although this provision would be reinstated.

Systems were either not in place or robust enough to demonstrate people's care was person centred. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People's care was provided by a team of staff who knew people well and people told us that staff listened to them. One person said, "They [staff] know I like to keep busy. They let me go out for walks to keep fit."

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.

- People's care plans contained basic information about people's communication needs. However,

information was not always made available to people in a format they could understand. For example, menus were not available in a pictorial format to support people's understanding of the food they were being offered.

Improving care quality in response to complaints or concerns

● Complaints had been logged by the registered manager and there was a system in place to ensure that complaints which were identified and dealt with were adequately recorded and responded to.

● However, during the inspection people and their relatives told us when they had raised concerns about their care with staff, it had not been recognised that they may wish to make a complaint and have their concerns formally investigated. This meant there were no records to reflect that problems were occurring, and actions weren't taken in response.

End of life care and support

● Although the service was not providing end of life care at the time of inspection, this was something they provided to people when needed.

● People had not been given the opportunity to record what was important to them at end of life. The provider was aware of this and planned to develop end of life care planning for people.

● Where people had a Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) form in place, this information was accessible to staff. A DNACPR order informs health and social care staff that a person with capacity has expressed a clear wish not to be given cardio-pulmonary resuscitation.

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

At our last inspection the provider did not have systems in place to assess, monitor and mitigate risks relating to people's safety and welfare. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- The provider had failed to implement effective governance systems or processes and had not effectively assessed, monitored or driven improvement in the quality and safety of the care being provided in the home.
- Although the provider's own internal processes had identified some concerns about the adequacy, safety and quality of care they had failed to take the necessary action to drive improvement and secure compliance in relation to the regulatory requirements. This meant people living in the home were exposed to unnecessary and unacceptable levels of risk.
- People could not be assured of safe care and treatment as this was not being effectively monitored. There was a lack of oversight of peoples choking, falls, skin integrity and nutritional risks in the home. Where risks to people had been highlighted, it had not been identified that staff were not following the systems in place to reduce this risk.
- The systems in place to monitor the environment and infection control had not resulted in a safe environment where fire and infection control risks were adequately managed.
- Staffing levels weren't assessed or monitored to ensure people's safety. The provider had not effectively assessed staffing needs and we found staffing levels to be inadequate during our inspection. Staff were unable to deliver safe care and support due to the staffing numbers, however, this had not been identified as an issue.
- The governance system in place had failed to ensure there were enough suitably trained staff available to provide people's care. There had been no oversight of staff training and a recent audit had identified that records did not accurately reflect the training staff had received. Staff were recorded as completing training they did not hold certificates for and the provider did not know whether staff had received this training or not.
- Other than an audit of staff files no provider audits had been done. The nominated individual told us they were aware of the issues in the home, but no other formal checks of the service had been completed. The

provider had failed to identify the areas of risk and concern and had not identified how these areas would be rectified.
● Systems in place for care plan reviews stated care plans and assessments were to be reviewed monthly. No care plans and assessments looked at during the inspection had been reviewed since August 2019.
● No system had been implemented to enable people or their relatives to receive regular review meetings. All the people and relatives we spoke with said that apart from the initial pre-assessment they were not invited to reviews and had no knowledge of what was in their care plans.
● There had been a lack of oversight of people's Deprivation of Liberty (DoLS) applications. As a result, five people's authorisations had expired and there had been a delay before a new authorisation was requested.
● The system in place to ensure people's personal information was stored securely was ineffective. We found people's care plans and records were stored in an insecure cupboard in the entrance corridor. The lack of secure storage of people's confidential information had been raised at the last inspection on 21 November 2018.

The provider did not have suitable systems in place to assess, monitor or mitigate risks relating to people's health and welfare. This was a continued breach of Regulation 17 (1) of the Health and Social Care Act (Regulated Activities) Regulations 2014. Good governance

● Staff provided positive feedback about the registered manager. One member of staff said, "Teamwork has improved, I feel absolutely everything has improved, residents and staff seem happier, I enjoy coming to work now, the manager cares about us and is approachable."
● The provider had displayed their most recent CQC rating as required and had provided statutory notifications to CQC for any notifiable incidents.

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 management team were aware of the requirements under the duty of candour. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. People and their relatives told us staff and the registered manager were open and transparent. One person's relative said, "I can always knock on the office door and [registered manager] will help. [Registered manager] has done a good job since they got here."
● Staff knew how to 'whistle-blow' and knew how to raise concerns with the local authority and the Care Quality Commission (CQC) if they felt they were not being listened to or their concerns acted upon.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care
● Regular meetings took place for people, relatives and staff. The staff meetings covered a variety of topics including; medicines, care plans and nutrition. However, the discussions that took place during these meetings had not resulted in the improvements that were required to people's care.
● The provider gathered people's views of the service they received through quality assurance surveys. We saw survey responses were generally positive, but people and staff had asked for more activities for people in the most recent survey.

Working in partnership with others
● Representatives from the local authority quality team had conducted monitoring visits and identified concerns with the service. The registered manager was working with the local authority to make the improvements needed.

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 9 HSCA RA Regulations 2014 Person-centred care People's care was not provided in a person-centred way.

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 Risks to people had not always been identified and managed safely. Action to minimise risks to people's health and wellbeing had not always been taken and this put people at risk of harm.

The enforcement action we took:

Imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People were at risk from malnutrition and did not receive the support they needed with eating and drinking. Where people had lost weight sufficient action had not been taken.

The enforcement action we took:

Imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance At our last inspection the provider did not have systems in place to assess, monitor and mitigate risks relating to people's safety and welfare. At this inspection we found the provider had failed to implement effective governance systems or processes and had not effectively assessed, monitored or driven improvement in the quality and safety of the care being provided in the home.

The enforcement action we took:

Imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff deployed to meet people's needs. The provider had not ensured that staff had received the training required to enable them to fulfil the requirements of their role.

The enforcement action we took:

Imposed conditions on the provider's registration.