Barker Care Limited

St Teresa's Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
St Teresa's Nursing Home is a nursing home and was providing personal and nursing care to 66 people aged 65 and over at the time of the inspection. The service can support up to 70 people.

The home is laid out over three floors and areas within the home have been separated into three 'wings': Gainsborough Wing, Bartelt Wing and Austen Wing. People are placed on wings according to their needs, for example nursing or dementia care. There are communal toilets and bathrooms located throughout each wing. Most rooms have en-suite facilities including a shower, hand-washing facilities and toilet. People have access to communal lounges and dining areas within the home. There is level access to a patio area with seating and tables and views across the garden. There are a number of smaller accessible outdoor spaces that are decked or patioed. The manager's office is located close to the main entrance. There is parking available on site.

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

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 were not always protected from the risk of avoidable harm and potential abuse. This was because assessment, guidance for staff, processes and practice were not always robust, comprehensive or safe. For example, safeguarding concerns were not always correctly identified and this meant the local safeguarding team were not always contacted appropriately. People told us there were insufficient numbers of staff to meet their needs, staff confirmed this. Environmental hazards were not consistently identified this meant actions were not taken to ensure the environment was safe for people. We also found gaps in records associated with the management and administration of medicines.

Peoples' needs were not always assessed and when their needs changed assessments were not consistently reviewed. This included a lack of robust assessment regarding the use of air mattresses. People were not always supported by staff with relevant training and who had received regular supportive supervision sessions. When people lacked capacity to make a specific decision, capacity assessments did not always include information about the specific decision that needed to be made. Further 'photograph consent forms' were used inappropriately, for example relatives without Lasting Power of Attorney (LPA) signing on behalf of the person. For those who required it, food and fluid intake and targets were set and monitored appropriately.

Staff did not have sufficient time to provide unrushed care, however people told us they received support from staff who were caring. Staff spoke about people in a person-centred way. Information about people who required modified diets was displayed in communal areas and this was not dignified for people. On

occasion, we observed a task focussed approach to providing people with care.

There were systemic failures in relation to oversight and audits of the service; audits had not been used effectively to identify concerns, errors and omissions we identified during the inspection. When audits had identified actions were required, plans did not always include relevant information, such as time frames and who was responsible for implementing changes. Peoples' confidential information was not always stored securely and was accessible to people and visitors to the home. The provider did not always submit statutory notifications to the Commission as required, further notifications were not submitted 'without delay'. People and staff spoke positively about the manager.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 14.

Fluid and food targets for people were being calculated correctly and monitored at appropriate intervals.

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 August 2018)

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 based on the previous rating.

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 improvements. Please see the Well-Led, Effective, Responsive and Safe sections of this full report.

The provider contacted us after the inspection and informed us about actions they would take to improve safety. Actions included auditing areas of concern highlighted during the inspection, having discussions with staff about relevant topics and providing opportunities for staff to access further training and information. An additional manager was allocated to the home to help drive improvement and improve monitoring of the service.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for St Teresa's Nursing Home on our website at www.cqc.org.uk.

Enforcement

Since the last inspection we recognised that the provider had failed to ensure people received safe care and treatment. This was a breach of regulation. Full information about CQC's regulatory response to this is added to reports after any representations and appeals have been concluded.

We have identified breaches in relation to health and safety, assessment, person-centred care and failure to

work in accordance with the Mental Capacity Act (2005). The service was not well-led and this meant audits were not used effectively to identify errors and omissions. There was a further failure to ensure statutory notifications were consistently submitted to the commission and 'without delay'.

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.

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 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

St Teresa's 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 was made up of two inspectors, an assistant inspector, specialist advisor and 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
At the time of our inspection, the manager was not registered with the Commission, although their application to register had been received.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from professionals who work with 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 staff including the manager, area manager, care staff and registered nurses. We spoke with ten people using the service about their experiences and four relatives.

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 reviewed a range of records. This included 12 people's care records and multiple medication records. We looked at three staff files in relation to recruitment and reviewed the training matrix. 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 Good. 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; Preventing and controlling infection; Using medicines safely;

- Assessments, processes and staff practice did not always help to ensure people were protected from the risk of potential harm.
- We observed one person who was not mobile being transferred in their wheelchair, the person was sat on a hoist sling. The person needed to be transferred from their wheelchair to a chair using a hoist and sling. However, we observed the sling was not being used correctly and requested the transfer was stopped. Once the transfer was stopped, staff identified the incorrect sling was being used. The correct sling was found, and staff transferred the person safely into a chair. We reviewed the person's manual handling assessment and found there was limited guidance available for staff about how they should support the person with the use of equipment. For example, the only guidance available about the type of sling that should be used was the size. The person's assessment recorded they required a 'medium sling', further relevant information, such as the type of sling the person should use and information about whether the sling was suitable to remain 'in-situ' in between transfers was not available to staff.
- Environmental hazards were not always identified. For example, during the inspection we observed rolled turf on a decked area accessible to people, posing a trip hazard. Further hazards included, an unlocked and open sluice door, straws touching a can of air freshener. We brought this to the attention of the area manager and manager, they acted to remove the rolled-up turf and disposed of the air fresheners and straws.
- Nutritional supplements were not stored safely. Three containers of drinks thickener were not stored securely. Thickeners should be stored securely because if they are used incorrectly, for example unmixed thickening powder is ingested, there is a risk the powder will expand and block a person's airway. We also found nutritional drinks that had been prescribed in November 2018 on the side in a communal lounge and a sachet of 'powdered drink mix' in the same lounge.
- People were not always protected from the spread of infection.
- In the kitchen we found food stored in the freezer in bags which had not been sealed, we also saw food which had not been dated after being put into the fridge. The kitchen floor was dirty in places and required a deep clean.
- Communal bathrooms and toilets throughout the home were used to store laundry, for example on a bath seat and trolley, this included people's underwear and blankets.
- In the laundry, the floor behind the washing machines was wet and flooded from a broken machine. There were items stored on top of the washing and drying machines, and clean upholstery stuffing pushed down the side of the wall next to the washing machine which handled dirty linen. Clean linen was stored in the

laundry and had to pass by open baskets of dirty linen when exiting the laundry.
● Medicines were not always managed safely.
● We found gaps in the records. For example, one person's Medication Administration Record (MAR) recorded the person needed to take a certain type of medicine and guided staff to, "Try not to miss doses" however we found one occasion when there was a gap in the MAR. When people required 'as required medicines' there was guidance available for staff such as why the person should have the medicine and potential side effects. However, there was no information to guide staff about how much time there should be between doses.
● MARs did not always include an area for staff to record the reason why medicines were not administered so this could be monitored accurately.

People were at risk from avoidable harm because processes, procedures and practice did not support the provision of safe care and treatment.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's medicines information sheets were completed and included important information, such as information about a person's allergies.
● Medicines in the stockroom were stored correctly, this included monitoring the temperatures of the room and fridge to ensure they remained within safe limits.

Staffing and recruitment
● People and staff, we spoke with told us staffing levels in the home were not sufficient. Comments from people included, "Carers [are] good but short staffed at times" and, "Not enough staff - do wait a bit sometimes. They work so hard". Comments from staff included, "At the moment there's not enough staff, especially in the summer time as people go on holiday" and, "Sometimes we need more staff, because when it's holiday we don't have that many". We also observed that care staff spent very little time with people unless they were carrying out a task.
● The provider was using a tool to determine staffing levels. The tool looked at the individual needs of people, including levels of support required to use the toilet, eat and move around. On the first day of the inspection, the manager told us the dependency tool we reviewed was out of date.
● Staff were recruited safely. Appropriate checks, such as those with previous employers and the Disclosure and Barring Service (DBS) were undertaken. DBS checks are important as they help prevent the service employing people who may be unsuitable to work in care.
●We reviewed the staffing rotas for a total of eight weeks and found at least four occasions when staffing levels fell below the assessed levels.

Systems and processes to safeguard people from the risk of abuse
● Systems and processes were not sufficiently embedded to ensure people were protected from potential harm and abuse.
● Safeguarding concerns were not consistently identified, and this meant appropriate actions were not always taken by the provider. For example, we found the local safeguarding team had not been contacted about an allegation of neglect, the allegation had been incorrectly recorded as a complaint.
● When unexplained bruising occurred, the provider had not always contacted the local safeguarding team. For example, one person's care plan included a photograph and body map documenting a bruise. The cause of the bruise was recorded as 'unknown'. No further action had been taken to explore how the bruise

occurred and contact had not been made with the local safeguarding team.

Potential safeguarding concerns were not always identified as such and incidents of unexplained bruising were not always referred appropriately, meaning people were at risk from potential abuse.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff spoke confidently about how they would identify potential abuse and what actions they would take if abuse was suspected. Comments from staff included, "I would stop abuse, it would not continue. I would report it to the nurse in charge and the manager" and, "I haven't seen any abuse. I would make sure the person is safe and report abuse straight away."

Learning lessons when things go wrong
● We were not assured that the provider learned lessons when things went wrong.
● There had been no incidents or accidents recorded for people other than falls since March 2019. However, we found people had sustained bruising and that these events had not been recorded as incidents for further investigation to reduce recurrence or identify abuse. By not analysing these incidents the provider had not ensured appropriate measures were in place to reduce these risks.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same.

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

Staff support: induction, training, skills and experience
- Staff did not consistently receive training relevant to their role or the people they supported.
- We reviewed the training matrix and found eight staff had not received any of the provider's mandatory online training in subject areas including, manual handling and safeguarding adults. The training matrix showed further staff members had gaps in their training around specific topics. One staff member said, "We need more support about people with dementia, some people can hit or kick me."
- We reviewed three staff files in relation to supervision sessions. The staff had not received their 'Individual supportive supervision' sessions in line with the provider's policy.

Staff did not always receive training relevant to their roles and to the people they were supporting.

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

- We received mixed feedback from people about whether or not they were supported by staff who were well trained. Comments from people included, "Not enough training, especially in the command of the English language, find it difficult to understand what carers are saying sometimes" and, "Very well trained. Confidence in all of them." One staff member said, "I think they should give a bit more training for everyone, even if staff have done the training before, they should have a refresher."
- Staff received an induction that was aligned with the Care Certificate. The Care Certificate is a set of fifteen standards containing information that all staff new to care should know.
- The manager was exploring ways to improve training available to staff. For example, contacting the local speech and language therapy team who were scheduled to meet with staff and provide training. Some staff had also recently attended British Sign Language training.

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.

● The provider did not protect the rights of people living in the home in line with the Mental Capacity Act 2005.
● Records of best interest decisions were not always decision specific or were incomplete and did not always ensure decisions were truly in person's best interest.
● One person had a best interest decision which stated the decision to be made was 'DNAR'. DNAR means 'do not resuscitate', 'DNAR' was not an adequate written explanation of the decision to be made. There was conflicting information in the sections which stated, 'Can the decision be delayed because the person is likely to regain capacity in the future?' and 'Not likely to regain capacity' as were both ticked. The views of people involved in making the decision were a GP, and a staff member from the service. A relative was also listed but their view not written on the document. This document was recently completed in August 2019. The completed DNAR document had not been dated, the mental capacity assessment section had not been completed, and it stated that the relative's view had been obtained for which we found no evidence.
● A 'Consent to Photographs' form had been signed by a relative in the person's 'best interest' as the person did not have the capacity to consent. The relative did not have a lasting power of attorney to make decisions for the person or to provide consent on their behalf. In addition to this, the sections of the form which gave permission for the person's photos to be used as part of the providers publicity and service literature had been ticked. This was not in the person's best interest.

Capacity assessments and best interest decisions were not always completed in line with the principles of the Mental Capacity Act (2005)

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At the time of our inspection, 49 people were subject to DoLS. The provider applied for DoLS appropriately.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Assessments did not always contain relevant information and information that was significant was not always followed-up or recorded during the assessment process. This meant staff were unable to access relevant guidance.
● We reviewed one person's care plan that detailed information about a wound, a hand-written note stated, "PLEASE ASSESS". There was no evidence that action had been taken to assess the wound. We brought this to the attention of the manager who confirmed no assessment of the person's wound had been completed since their admission into the home. Another person's care plan included guidance for staff that the person could be, "Un-cooperative at times" when being transferred with the use of a hoist. There was no guidance available for staff about how the person may be 'un-cooperative or how to reassure the person and help to make the transfer a more pleasant experience.

● One person was receiving pain relief medicines. When one of the pain relief medicines was stopped and another was changed, the person's Pain care plan had not been reviewed and updated to ensure they were still receiving effective pain relief.
● Prior to moving into the home, one person was assessed by an external professional as being at risk of falls because of their, "Dementia and anxiety". The falls section of the service's pre-assessment document was not completed with any details of this risk.
●The provider could not be sure people's pressure relieving mattresses were on the correct setting to be effective. One person's pressure relieving mattress was on the incorrect setting according to their weight, the correct setting of the mattress was not available to staff. We checked the settings of three more pressure relieving mattresses and information was not available about what settings these mattresses should be. We spoke with the manager and area manager about the settings of these mattresses. The manager and area manager could not provide us with the information so contacted the manufacturer and searched for guidance about the air mattress settings using the internet.

Assessments of peoples' needs did not always contain current relevant information and guidance for staff.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● The food looked appetising and people spoke positively about the food choices available. Comments from people included, "Enjoy the food. Different food if you don't want what's on the menu. Do a good roast dinner" and, "Good choice of meals. If it isn't what you like, tell them and they will make you something else."
● Some people living in the home required modified foods because of swallowing difficulties.
● The provider was not always working in line with published guidance about best practice. For example, guidance for staff about textured diets for people with swallowing difficulties was not always produced in line with the recommended framework.
● Recent changes to published guidance means modified foods should be described using 'levels' rather than 'textures'. We found the provider was using different terms to describe modified foods. For example, one person's care plan described them needing a, "Textured E diet" and another person's care plan recorded they required a "Type 7 diet", information from the Speech and Language Therapy team confirmed the person should be receiving Level 7 modified food.
● The dining rooms in the service were mainly unused. Some people in the Bartelt unit were able to eat in a dining room where there were dining tables set with linen and place settings, creating a sociable atmosphere. People who had more complex needs in the Gainsborough unit ate their meals on small tables in front of them in the lounge. This was neither comfortable or sociable for people. We observed people hunched over their side tables with little or no conversation between them and the staff. The food service was run like a task focused exercise rather than a sociable and pleasant experience for people. There were no condiments or place settings or anything that would make dining a more pleasant experience.
● We saw menus placed in the dining room and lounges for people to read. The service ran a four-week rotating menu. It was week one on the day of our visit. There were conflicting menus on view. In one dining room, there were three menus for week four and two menus for week one. In another setting the menu for week four was available to read. Additionally, information on a white board in larger handwriting referred to the daily menu from three days previously. This was not helpful for people living with dementia who may already be experiencing confusion and disorientation.

Staff working with other agencies to provide consistent, effective, timely care

● Overall the provider worked with health care professionals and the interactions were recorded in peoples' care plans. However, we found one person who was identified as having lost weight and the care plan did not record involvement from a dietician or other relevant healthcare professional.
● We received positive feedback from healthcare professionals about their experience of working with staff. One healthcare professional said, "The staff know the residents well and they alert us, in a timely fashion, when they are unwell or have concerns about them."

Adapting service, design, decoration to meet people's needs
● The decoration within the service had not been adapted to meet people's needs. There were few adaptations to support people living with sensory impairment or dementia to navigate around the home. There was no attempt to differentiate between areas of the home which would be helpful for visitors as well as for residents and there were few items or decor which may stimulate memories for people.

Supporting people to live healthier lives, access healthcare services and support
● People told us they were supported to access healthcare services. Comments from people included, "GP comes in once a week and checks to see if there is something wrong" and, "Last week the optician came here said everything was ok."

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

● Although all people spoke positively about the staff providing care, they did feedback that staff did not always have time to deliver unrushed care. Comments from people included, "Carers show compassion and they are more or less efficient. The only thing is that everything is done in a hurry because they have the next person waiting" and, "Get on very well with the carers, can communicate with them but sometimes difficult to catch what they are saying. Care in a way [is] rushed." One relative said, "Wonderful home, staff very good. Only thing is that quite a few lovely carers are leaving."

● People told us that staff were caring, comments from people included, "Can't fault any of the carers. Always on the ball, kind, always pick up if you are not well. The other day I had priority because I wasn't well" and, "Staff treat me very nicely- kind people". Comments from relatives included, "Carers, can't sing their praises enough. Carers lovely."

● People's spiritual and religious needs were met. Comments from people included, "Religion has always been important part of my life. I do take communion here".

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

● There was a culture amongst staff of being task orientated, we saw this affected how people were offered choices. We observed one person being offered breakfast. The staff member asked them if they would like breakfast, to which they nodded yes. The person was then asked if they'd like some scrambled egg, to which they nodded yes. The person was given a plate of scrambled egg with no other breakfast items or condiments or offered anything further. The staff member poured a cup of tea for the person without asking them their choice of drinks.

● People told us they were involved with making decisions about their care. Comments from people included, "Care plan-know what they are doing, talk about my care if things change." Comments from relatives included, "Have had a review of care. If anything else needed would speak to the nurses" and, "Happy with the care plan or I would speak up."

Respecting and promoting people's privacy, dignity and independence

● We saw information about people's dietary needs up on walls for everyone to see. This was not dignified for people.

● People told us their privacy was respected. Comments from people included, "They [staff] know that I like my private space. Not a great mixer and like to be in my room" and, "[Staff] knock on my door [and] say, "Can we come in?""

● People told us staff supported them to maintain their independence and they felt respected by staff. Comments from people included, "[Staff] asked if things are ok. Trying to get me to walk to the bathroom, got the occupational therapist in for me" and, "Always treated respectfully by the carers."
● People told us staff asked for their consent before providing personal care. Comments from people included, "If I need something doing they [staff] always ask me, "Is this ok?" before they do any personal care or showering" and, "[Staff] do get me up and help me to get in my chair. Always ask me first if it's alright to help."

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.

Supporting people to develop and maintain relationships to avoid social isolation

- The way in which the service was run did not encourage friendships between people. There was very little interaction between people who stayed in their rooms and people living with complex dementia. Most people in the Gainsborough wing did not move from the lounge all day and remained there for all their meals.
- On the first day of our inspection there were no social activities available to people. We observed that people in the Gainsborough wing lounge experienced very little interaction between people and staff.
- People were not always supported to access activities that were meaningful and relevant to them. For example, one person's care plan recorded staff should support the person to access the garden on a warm day. However, from the 1 to 28 August 2019, the person's activity log recorded the person had only been supported to go into the garden once and there was no record detailing whether the person had been asked and declined on other days. Another person's care plan guided staff to, "Enable [person's name] to walk around the home and gardens, join in with dancing and ball games etc", the person's activity log recorded ticks on four occasions from 1 to 28 August 2019, there was no further details about which of the activities they had been involved with.

People were not always supported to avoid social isolation through the development of relationships and access to activities that were meaningful to them.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The manager confirmed activities was an area for development. Recent changes had been made, including the allocation of staff for one to one activity. There was a vacancy for an activity coordinator, the manager had recently appointed a person who was due to start in the next few weeks.
- People who accessed activities spoke positively about their experiences. Comments from people included, "Go to all the things, always go to the singing and like the quizzes, keeps the brain going and helps you to keep on top of things" and, "There are activities any afternoon, enjoy going to most things. A lady comes in to do exercises".

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 provider had taken some steps to ensure information was accessible to people. For example, photographs of some foods were available, one staff member said, "There are some pictures, but not with all the food."

● We requested further information about how the provider was meeting the AIS, however to date this information has not been received.

● One person's care plan contained conflicting information about how they could communicate. Information stated they used non- verbal communication but also stated they could speak. No effort was made to try other forms of communication

We recommend the provider consult published guidance about best practice in relation to the Accessible Information Standards.

Improving care quality in response to complaints or concerns

● Complaints were dealt with appropriately, for example one person' mobile phone was put through the washing machine and the person was reimbursed the cost of the phone. Although we did find one complaint that had not initially been acknowledged by the provider and this meant the complainant had to follow up the initial complaint with a second letter.

● There was no evidence to show the provider was revisiting complaints and concerns as a way of driving improvement and improving peoples' experiences of care.

● People and their relatives told us they felt able to complain and that appropriate actions would be taken. Comments from relatives included, "Only have to go to [Name of manager] with a concern and [they] will look in to it and sort it out. [They] will keep me informed about what is being done" and one person said, "Anything wrong and I would tell the carer and I know that it would be put right."

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

● Overall people's care plans did include information about peoples' preferences. For example, how people wished to carry out their bed time routine and their food preferences. However, there was gaps in this information. For example, two people were receiving a modified diet and their care plans did not include information about their favourite foods.

● The manager told us they made every effort to undertake assessments immediately for people who were looking to move into the home, for example visiting a person for their assessment on the same day as their enquiry was made.

End of life care and support

● Relatives provided positive feedback about their loved ones' experience of End of Life care and support. Comments from people included, "Right from the assessment completed by, [manager's name] on that same day, to the day she died, [Person's name] received magnificent care. I cannot praise the staff highly enough for the care and support offered."

● When people moved into the home, their End of Life preferences were explored and recorded.

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

● There were widespread and systemic failings identified during the inspection; we identified seven breaches of regulations; the shortfalls related to key aspects of the service; safeguarding, safe care and treatment, treating people with dignity and respect, person centred care, staffing, statutory notifications and good governance

● People's confidential information, such as information about their care and corresponding personal details, was not always stored securely. For example, we found hydration charts, turning records and care plans stored in communal areas accessible to people and visitors.

● The provider's quality assurance systems and processes did not ensure that they were able to mitigate the risks relating to the health, safety and welfare of people and others who may be at risk in the service. The quality assurance systems were ineffective in directing sufficient resources into the areas that required improvement within a reasonable timescale.

● Senior staff within the service had undertaken audits of several areas and had failed to identify the shortfalls we found. We found one provider level quality audit which was undertaken in the two weeks prior to the inspection which identified some of the issues we found however, we found no other evidence of provider oversight in the last 12 months.

● Action plans from audits where issues had been identified were not followed up with actions taken and timescales for completion. For example, the infection control manager's audit identified in January, April and July 2019 that there was no lockable gate to the external waste area, this was noted three times with no timescale for action or any initiated action recorded.

● Poor governance of the service was a theme with staff undertaking audits of their own work or work areas and failing to identify shortfalls. For example, housekeeping staff auditing the cleanliness and condition of areas they cleaned.

●The management structure did not reflect the size and layout of the service to support effective oversight. There was no clinical lead or deputy manager to enable delegation and management of the service when the registered manager was not available.

This had been exacerbated by a recent high turnover of staff.

● There was not an effective system to monitor the quality of peoples' care records and ensure the service held current and accurate records about people. Records did not always contain enough information about people to protect them from the risk of unsafe care. There was also a failure to identify recording errors and

omissions in the care records and to analyse concerns. We saw records which were incomplete and incorrect.
●The absence of a robust governance system to ensure records were analysed and completed accurately by staff exposed people to risks of unsafe or inappropriate care or treatment.
The lack of oversight and ineffective use of audits meant the service was not well-led and this resulted in widespread and systemic shortfalls.

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

● All services registered must notify the Commission about certain changes, events and incidents affecting their service or the people who use it. Notifications tell us about significant events that happen in the service. We use this information to monitor the service and to check how events have been handled. Notifications were not consistently submitted to the Commission as required.
● We had not received statutory notifications when the lift used by people had been out of service for at least four days in January 2019.
● Notifications regarding alleged and potential abuse were not always submitted. For example, when a person was slapped by another person using the service.
● We did not always receive notifications without delay, as required. One notification was made 44 days after the notifiable event occurred and another made 31 days after another notifiable event. This meant that the Commission had been unable to monitor the concerns promptly and consider any follow up action that may have been required.

Statutory notifications were not always submitted to the Commission as required and were not always submitted 'without delay'.

The failure to notify as required was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009

● Staff, relatives and people spoke positively about the registered manager. Comments from relatives included, "Good manager who is trying to put things right" and one person said, "[Manager's name] is lovely, comes in to see me, asks how I am and how things are going. [They have] a good rapport with my son". Comments from staff included, "The manager gives us a lot of support, of all the homes I've worked in this manager is the best I've seen, cares about the staff and residents as well."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider asked people and relatives for their views on various aspects of the home annually. We looked at the results from the latest survey undertaken and found the responses of the people surveyed were mainly positive.
● Where issues or ideas had been raised at resident meetings, there was not always a clear action plan or response to issues raised.
● There were no relatives meetings taking place to enable relatives to collectively share their thoughts and ideas and give feedback to the provider.
● Staff meetings took place but were not regular, minutes were also not always made; this combined with the lack of supervisions meant there was limited opportunities to ensure information was shared and expected standards were clear. One staff member said, "We had a team meeting a couple of months ago. They're not as often as they should be."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Staff told us there was a team spirit. Comments from people included, "Good team and since [Manager's name] came it's been brilliant, it's a huge change - when I started the team work was broken, but now everyone has settled well

● Staff we spoke with had a person-centred outlook. Comments from staff included, "The staff try to do everything perfect for the residents" and, "I like to see when the residents and the family are pleased with us and people are happy and when relatives come, and their mum or dad look happy, well dressed and have good food."

Continuous learning and improving care

● There was no evidence available to demonstrate the provider was learning and implementing the lessons learned to improve peoples' experiences of care.

Working in partnership with others

● The manager was working to build links with the community, this included two local religious organisations and local schools visited at Christmas to sing songs.

● The provider had recently organised a fete and this was attended by those in the local community. One relative said, [Name of activity coordinator] works hard. We had a successful fete. If the entertainment is on I go with [name of person]."

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 was aware of their responsibilities in relation to the duty of candour.

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 18 Registration Regulations 2009 Notifications of other incidents Statutory notifications were not always submitted to the Commission as required and were not always submitted 'without delay'.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Assessments of peoples' needs did not always contain current relevant information and guidance for staff. People were not always supported to avoid social isolation through the development of relationships and access to activities that were meaningful to them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Capacity assessments and best interest decisions were not always completed in line with the principles of the Mental Capacity Act (2005)

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 Potential safeguarding concerns were not

always identified as such and incidents of unexplained bruising were not always referred appropriately, meaning people were at risk from potential abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The lack of oversight and ineffective use of audits meant the service was not well-led and this resulted in widespread and systemic shortfalls.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not always receive training relevant to their roles and to the people they were supporting.

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 People were at risk from avoidable harm because processes, procedures and practice did not support the provision of safe care and treatment.

The enforcement action we took:

Warning Notice.