

Indigo Care Services Limited

The Heathers Nursing Home

Inspection report

Gorsemoor Road
Cannock
Staffordshire
WS12 3HR

Tel: 01543270077

Date of inspection visit:
14 January 2020
15 January 2020

Date of publication:
22 June 2020

Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Requires Improvement 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

About the service

The Heathers Nursing Home provides personal and nursing care to 35 people. The service can support up to 53 people.

The Heathers Nursing Home is located in residential area and accessible to all local amenities. The home is situated on two floors which are accessible via a passenger lift or stairs. The ground floor is specific for people receiving nursing care. Whilst the first floor is dedicated to people living with dementia.

All bedrooms are of single occupancy and equipped with essential furnishings. People had access to communal areas. Bathrooms and toilets are located on both floors and near to communal areas. People have access to a garden at the rear of the property.

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

There was a manager in place. However, at the time of the inspection they had not yet registered with CQC. We found the provider's governance was ineffective to review, assess and monitor the quality of the service provided to people. This placed people at risk of their specific needs not being met.

The management of people's prescribed medicines were unsafe because written protocols were not always followed. Staff did not always adhere to information within risk assessments and this compromised people's safety. Staff did not have the skills or understanding about how to support people to manage their behaviours when they became agitated and distressed.

Staff did not always demonstrate a caring approach and people's right to dignity was not always respected. There were insufficient systems in place to assist people to make decisions which, placed them at risk of not receiving care and support the way they like. People's interests had been explored but they were not supported to pursue them. There was no evidence people were supported to engage in meaningful activities to ensure they have positive experiences.

Apart from pictorial menus there were no other systems in place to assist people to communicate their needs. There was no evidence to show people's involvement in decisions about planning or reviewing their care and treatment. We found the culture of the home was not caring where staff showed very little empathy to people living with dementia.

Staff told us there were not always enough staff on duty to have meaningful engagement with people. Detailed oral health care plans were not in place to promote good oral health. Staff were not always provided with essential training to ensure they had the skills to meet people's needs safely or effectively.

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 procedures at the

Heathers Nursing Home did not support good practice.

New staff were provided with an induction into their new role and all staff had access to one to one supervision sessions to support them in their role. The provider worked with other agencies in providing a service to people. The home was purpose built and although some areas were in need of decorating, essential furnishings were provided.

The assessments of people's needs were carried out before they moved into the home. People were supported by staff to access healthcare services. People were supported by staff to eat and drink sufficient amounts to ensure their health.

People were unable to tell us if they felt safe living in the home. Although staff demonstrated a good understanding about various forms of abuse and how to safeguard people from this. They did not recognise behaviour management and medicines practices were not appropriate and placed people at the risk of abuse. We found the provider's recruitment process ensured staff were suitable to work in the home. We observed the home was clean and tidy and audits were carried out to ensure hygiene standards were maintained. The manager was aware of their responsibility to take action when things went wrong to avoid it happening again.

Complaints were listened to and acted on. No one at the time of our inspection was receiving end of life care. However, where people had capacity their wishes in relation to their end of life care had been obtained and recorded. The manager was aware of some of the shortfalls identified during the inspection and was receptive to learning and making improvements to ensure people's specific needs were met.

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

The last rating for this service was requires improvement (published 14 January 2019), and there were multiple breaches of the regulations. At this inspection not enough improvements had been made and the provider was still in breach of regulations. The service remains rated requires improvement. This service has been rated requires improvement for the last four consecutive inspections.

Why we inspected

This was a planned inspection based on the previous rating.

We have found evidence that the provider needs to make improvements, to ensure the safe management of medicines. To ensure staff's practices reduce the identified risks to people. To ensure the care and support provided to people is person-centred and promotes their dignity. To ensure the governance is effective to monitor and improve the quality of the service.

Enforcement

We have identified breaches in relation to the management of medicines, practices that did not reduce the risk of harm to people, the care and support provided to people that was not person-centred or promoted their dignity and the ineffectiveness of the provider's governance at this inspection.

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

Follow up

We will request an action plan from the provider to understand what they will do to improve the standards

of quality and safety. We will work alongside the provider and 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.

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

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 always safe.

Details are in our safe findings below.

Requires Improvement ●

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 always well-led.

Details are in our well-Led findings below.

Requires Improvement ●

The Heathers Nursing Home

Detailed findings

Background to this inspection

The inspection

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

Inspection team

The inspection team consisted of two inspectors and an inspection manager.

Service and service type

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

The service did not have a manager registered with the Care Quality Commission. At the time of our inspection visit the manager was in the process of registering with us. A registered manager 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 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 reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used all of this information to plan our inspection.

During the inspection

During the inspection we spoke with one person who used the service, two relatives, four care staff, the laundry assistant and the laundry supervisor. We also spoke with the manager, the deputy manager, the regional director, a regional manager and an advanced nurse practitioner.

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

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.

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 remained the same.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

At our last inspection we found information contained in some risk assessments were inaccurate, bedrails were not fitted safely, medical intervention had not been sought in a timely manner and positive support plans were not in place to support staff's understanding about how to manage behaviours safely. This was a breach of regulation 12, Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- People were not always supported safely to reduce the risk of harm to them.
- We observed staff support a person with their mobility using a lifting equipment. The person did not have appropriate footwear on to ensure their safety whilst being assisted. Information in the person's care record showed, 'footwear should be worn.' We shared this concern with staff who acknowledged suitable footwear should be worn. However, staff did not take any action and continued to support the person without appropriate footwear which, placed them at risk of potential harm. One staff member told us, "We've done it like this before and they were okay." This meant staff did not follow instructions in the person's care record which, compromised the person's safety.
- One care record showed the person wore glasses. We observed they were not wearing glasses. The staff we spoke with were unaware the person wore glasses. Therefore, the person had not been supported by staff with their sensory impairment which, could compromise their safety and wellbeing.
- Some people required support with their behaviours. We found information provided to staff was conflicting about how many staff were required to safely support a person with their behaviours. We shared this information with the manager. After the first day of our inspection visit, the manager had reviewed the person's risk assessment and requested support from the mental health team. However, the manager was unaware of this discrepancy until we brought it to their attention.
- With reference to the same person, their care record showed five months prior to our inspection, a health professional said their medicines needed to be reviewed. However, we could not see any evidence this had been done. This placed the person at risk of not receiving the appropriate treatment. There was no positive behaviour plan in place to promote staff's understanding about how to assist the person safely with their behaviours.
- We shared concerns with the manager with regards to the lack of support to assist people with their

behaviours. The manager told us they had identified staff required training in behaviour management and they would be making arrangements to commission this training.

- We observed a person slipping off their chair. There were two care staff and a nurse in the room. However, this was ignored, and we had to bring this to staff's attention, to ensure the person was supported to sit safely in their chair.
- The provider had recently purchased a specialised chair. Discussions with the manager and the records we looked at confirmed a person using this chair had not been assessed to ensure this chair would be suitable to safely meet their needs.

Using medicines safely

- There were detailed written protocols in place to ensure the safe management of 'when required' medicines. These medicines are prescribed to be given only when needed. For example, for the treatment of anxiety. We observed a staff member failed to take actions outlined in the protocol that may have prevented the need for medication. This meant the person was given a medicine that may not have been necessary.
- Staff did not have access to clear information about the management of prescribed medicines and shampoos. Some staff used the MAR to show when prescribed creams had been applied and others used the hand held device. This meant we were unable to find out if people had received their treatment as prescribed.
- People's prescribed medicines were managed by qualified nurses who received competency assessments to promote safe practices. However, these assessment were not effective because we found shortfalls with the management of medicines.

People were not kept free from the risk of harm. This was a continued breach of regulation 12, Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Medicines were stored appropriately in accordance to the pharmaceutical manufacturer's instructions.
- Where medicines were intended to be administered covertly. A mental capacity assessment and a best interests decision was in place. Covert medication is a process where medicines are hidden in people's food. This had been agreed by the GP and the provider was awaiting approval from the pharmacist of which, they were pursuing on the day of our inspection.

Staffing and recruitment

- We receive mixed comments when we asked staff if there were always enough staff on duty. One staff member told us they did not have time to sit and talk with people. However, they confirmed this did not have an impact on the personal care provided.
- A different staff member told us, "Due to the staffing levels at times people are not able to get out of bed when they want to."
- We observed staff's routine was task orientated attending to people's care needs but no time engaging socially with people.
- The manager told us they had listened to staff views and was in the process of reviewing staffing levels and additional staffing would be provided where needed.
- People were supported by staff who had been recruited safely. All the staff we spoke with told us they had a Disclosure and Barring Service (DBS) check before they started to work in the home. DBS helps employers make safe recruitment decisions. We looked at three staff files which confirmed the undertaking of DBS checks and references were obtained.

Systems and processes to safeguard people from the risk of abuse

- People did not have the capacity to tell us if they felt safe living in the home. Staff were aware of various

forms of abuse and how to recognise these.

- Staff demonstrated a good understanding about abuse and how to safeguard people from this. However, staff's practices we observed, did not demonstrate this. For example, we found medicines practices were unsafe where protocols were not followed. We observed staff not following information in a risk assessment with regards to moving and handling which, placed the person at risk of potential harm. These practices placed people at risk of abuse.

Preventing and controlling infection

- We observed the home was clean and tidy. Staff told us they had access to personal protective equipment (PPE). The appropriate use of PPE helps to reduce the risk of cross infection.
- One staff member told us, "It's every one's responsibility to keep the home clean and tidy." Another staff member told us, "The nurses check that we are using PPE correctly and the manager observes our practices."
- An infection, prevention and control (IPC) lead was in place. This person was responsible for monitoring hygiene standards within the home and to promote good practices.
- The manager told us IPC was a standing agenda item in their daily, 'flash meetings.' During these meetings various topics were discussed relating to the quality of the service provided.

Learning lessons when things go wrong

- The manager had been in post since October 2019, and had identified some areas where improvements were required. They were aware of the importance of reviewing the service when things went wrong and to take action where necessary to avoid a reoccurrence. The manager told us they were in the process of reviewing staff training to ensure staff had the skills to provide a better service.

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.

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

At the last inspection the provider was in breach of regulation 11, Need for consent, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At that inspection we found mental capacity assessments had not been carried out before decisions were made on behalf of people. Not all the staff understood the Deprivation of Liberty Safeguards or ensured the least restrictive options were in place.

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 had taken some action since the last inspection to ensure where necessary mental capacity assessments were carried out and an application for a DoLS had been submitted to the local authority.
- The manager told us no one had an authorized DoLS in place. However, since their appointment they had identified some people required a DoLS to be compliant with the law. They told us 24 DoLS applications had been submitted to the local authority.
- The staff we spoke with understood MCA and DoLS. However, staff were unaware if anyone had a DoLS in place. A staff member told us the application on their hand device showed whether the individual had an authorised DoLS in place. However, when asked they were unable to demonstrate this. Staff's lack of understanding about who may have a DoLS in place could compromise the level of support people

received.

- A record showed one person had capacity to make decisions and the registered manager confirmed this. However, we observed the person had not been involved and had not signed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form. This meant attempts would not be made to resuscitate the person if they stopped breathing. There was no evidence the person had made a decision to have this in place and the manager was unable to explain this but assured us this would be looked into.
- Where people lacked capacity to make a decision we found apart from pictorial menus, there were no systems in place to help them make decisions. A staff member told us, "I show people things to give them a choice to point at what they want. We used flash cards in the past but not anymore. I feel this needs to be looked at to help people."
- We found that the least restrictive measures were not always used as we observed a person being administered medicines to control their behaviour before other methods were tried.

Supporting people to live healthier lives, access healthcare services and support

- Care records did not contain detailed information about oral care to ensure people received the appropriate support to maintain good oral health.
- A staff member told us a person had recently had dental surgery. However, there was no information recorded about appropriate aftercare in relation to their treatment to reduce the risk of infection.
- Discussions with staff and the records we looked at showed people had access to other healthcare services. A staff member told us, "We liaise with the community psychiatric nurse to support a person with their mental health."
- We spoke with an advanced nurse practitioner who told us they visited the home on a weekly basis. They told us their visits were unannounced. They said, "I have never seen anything that worries me."

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

- The manager told us a pre-admission assessment was carried out before people moved in to the home. We saw evidence of these assessments. These assessments enabled the provider to find out people's specific needs before they were admitted.

Staff support: induction, training, skills and experience

- Staff told us they were provided with an induction when they started to work in the home. One staff member told us, "I worked with an experienced staff member until I felt confident to work alone."
- Staff told us they had access to training relevant to their role. We shared concerns with the manager about behaviour management. The manager told us they had already identified this and were in the process of arranging behaviour management training for all the staff.
- The manager told us staff received one to one supervision sessions and this was confirmed by the staff we spoke with. One staff member told us, "In supervision when I get good feedback that's nice. It makes you want to do better, it gives you a boost." Access to supervision ensured staff were supported in their role to promote their understanding about how to meet people's needs.

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

- People were supported by staff to eat and drink enough to promote their health.
- Pictorial menus were available to help people choose their meal preferences.
- Staff were aware of people's dietary needs with regards to their health conditions, likes and dislikes.
- People had access to a dietician and a speech and language therapist when needed. These professionals provided advice and support about appropriate meals.
- Access to specialist equipment such as beakers, rimmed plates and thick handle cutlery promoted people's independence to eat and drink.

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

- Discussions with one person who used the service, their relatives and information contained within the care records showed the provider worked with other agencies in providing a service for people. This included social workers and other healthcare professionals.

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

- A staff member told us, "The home needs modernising and decorating and we could do with some proper linen to ensure people's comfort and to brighten the place up." A different staff member said, "The home would benefit from a lick of paint and linen and curtains that matched."
- We observed some areas of the home were tired looking and in need of minor repairs. For example, the unit on the first floor was sparse with little home comforts. On the ground floor the lock on the bathroom door was broken and this could compromise people's privacy. We shared this information with the manager who assured us the lock would be repaired.
- People had access to communal areas and bathrooms were located nearby.
- Grab rails were situated throughout the home to assist people with reduced mobility.

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

This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- Staff's approach was not always caring or respectful of the individual's needs.
- We observed a person waited 20 minutes for assistance with their personal care needs. Staff told us this was because there was only one item of lifting equipment in the home suitable to meet the person's mobility needs. This equipment was on another floor, being used by another person. This meant the provider was unable to meet this person's specific needs in a timely manner, so not to compromise their comfort and dignity.
- With regards to the same person, we observed them getting anxious whilst waiting for assistance with their personal care needs and they stood up. We heard a staff member say, "Sit yourself down," and guided them back into their chair. The person was not offered any reassurance.
- We observed one person was anxious and shouting constantly. This behaviour was identified in their care records and provided staff with information about how to support the person with this behaviour. However, we observed staff ignore the person and did not follow instructions in their care record about how to manage this behaviour.
- We spoke with one person who used the service who told us they had difficulty hearing because they did not have any batteries for their hearing aid. This meant staff had not taken the time to ensure the person's hearing aid was in working order. We shared this information with the manager and deputy manager who were unaware the person did not have any batteries for their hearing aid. They assured us action would be taken to address this.
- This demonstrated the service provided to people was not always caring.

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

- The care records we looked at did not contain any evidence of the person's involvement in making decisions about their care. A staff member told us people were not involved in decisions about their care. This meant people could not be assured they would receive a service specific to their needs.
- A staff member told us, "The hand-held device does not give detailed information about people's needs."

This is a breach of Regulation 9, Person-centred care, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Respecting and promoting people's privacy, dignity and independence

- People's right to privacy and dignity was not always respected by all staff. For example, we heard a person

ask for assistance to attend to their personal care needs. We heard a staff member say, "Why didn't you go before lunch, you'll have to wait now." The way the person was spoken to did not respect their right to dignity.

- We observed one person getting up from their chair several times and heard a staff member telling them to sit down for their safety. The staff member did not take the time to find out what the person wanted. The staff members approach did not respect the person's dignity.
- We saw a lock on one bathroom door was broken and the manager had not been made aware of this. This compromised people's dignity.

This is a breach of Regulation 10, Dignity and respect. of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Is the service responsive?

Our findings

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

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

This meant people's needs were not always met.

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

- A staff member told us they had been in post for four months and had not observed people having access to outdoor social activities. All the staff we spoke with told us there was a lack of social activities provided in the home.
- We observed people sat in the lounge with very little stimulation provided for them. The care plans we looked at showed the individual's interests but not all the staff we spoke with were aware of this.
- We observed one person getting up from their chair and heard a staff member repeatedly telling them to "Sit down." The staff member did not take the time to find out what the person wanted or to provide reassurance.
- Discussions with two care staff identified they were aware of one person's past hobbies and interests. However, they told us no activities had been considered to include this person's interests. A staff member told us, "A lot of people sleep maybe this is due to boredom."

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.

- We observed some people living with dementia were not always able to communicate their needs. Discussions with staff confirmed there were pictorial menus in place to help them choose their meal preferences. However, no other systems were in place to assist with communication. One staff member told us, "We used to use flash cards (pictorial cards) to help people to understand and to make a decision but we don't use them anymore."
- We observed the delivering of care was not always person-centred. For example, staff did not recognise when people were anxious, to reassure them or to follow instructions in their care record about how to support them when they became anxious.
- With reference to another person, there were no positive behaviour plans in place with regards to their specific needs.

This was a breach of regulation 9, Person-centred care of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

- The manager told us people's communication needs would be discussed during the pre-admission assessment. They told us flash cards would be reintroduced to assist people to express their needs. They said they were looking at reviewing electronic systems to help with communicate such as electronic tablets.
- The manager told us, "We have a multi-cultural staff team that can assist with translation.
- Records provided staff with some information relating to people's sexuality and religion.

Improving care quality in response to complaints or concerns

- We saw complaints made by relatives had been recorded and showed action taken to resolved them. For example, a visitor raised concerns about the lack of support to enable their relative to have a bath or shower. This was reviewed, and the person was assisted with their personal care needs at a frequency that suited them.

End of life care and support

- At the time of our inspection the registered manager confirmed no one was receiving end of life care.
- Where people had capacity information about their end of life wishes had been obtained and recorded. This should ensure staff are aware of the person's wishes with regards to their end of life care.
- Staff told us they had received end of life care training. Access to this training ensured staff had the knowledge and skills to care for people at the end of their life.

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 remained the same.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- At our last inspection the systems in place to monitor the quality and safety of the service were insufficient to drive improvements. The provider was in breach of multiple regulations. This was a breach of regulation 17, Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- At this inspection we found the provider had not taken enough action to comply with the regulations, to improve the quality of service provided to people and continued to be in breach of regulations.
- This provider has a history of non-compliance. For example, this is the fourth consecutive inspection, where they have required improvements and at the last inspection we reported breaches which, still have not been met.
- We found the provider's governance was ineffective to assess, monitor and to improve the quality and safety of the service. For example, monitoring systems in place did not identify staff did not have access to sufficient and accurate information relating to people's care and support needs.
- We observed a risk assessment showed the person was at high risk of falls. However, monitoring systems did not identify staff were not provided with information about how to reduce the risk. This placed people at risk of not receiving the relevant care and support.
- Quality assurance monitoring systems did not ensure staff understood the importance of following written instructions about when to administer 'when required' medicines. This placed people at risk of receiving unnecessary treatment.
- Monitoring systems did not identify or ensure people with a sensory impairment were provided with relevant support to ensure they had access to their glasses and that batteries were available for their hearing aids.
- Quality auditing systems did not ensure staff were aware of the importance of following information in risk assessments and this compromised people's safety. We observed staff assist a person with their mobility in an unsafe way.
- Monitoring checks did not identify staff were provided with conflicting information with regards to the use of bedrails. We also found staff had provided false information to show bedrails had been checked, when non-present in place.
- Monitoring checks did not identify that detailed oral health care plans were not in place to promote good oral health. Monitoring checks did not identify the absence of essential information about aftercare to reduce the risk of infection when a person had received dental treatment.

- Quality audits did not identify, that although one person had capacity to make decisions, they were not involved in a decision to have a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place.
- Monitoring systems did not ensure appropriate assessments of people's needs were carried out to ensure equipment were safe and appropriate to meet their needs. We observed one person was put in a specialist chair they had not been assessed for and this compromised their safety and wellbeing.
- Quality monitoring systems did not identify the absence of a positive behaviour plan for a one person to support staff's understanding about how to assist them safely.

The provider had not taken sufficient action to ensure people received a safe and effective service. This was a continued breach of regulation 17, Good Governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider had been without a registered manager for 12 months. The new manager had been in post since October 2019. At the time of our inspection visit the manager had not registered with us but was in the process of doing so.
- The management structure consisted of a manager and a deputy manager. There was an operations director and a regional director who were from an agency who provided the manager with support and supervision.

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

- A staff member described the culture of the home as "Lovely and friendly." Another staff member told us, "This is a nice place and we get on with everyone. There is a nice atmosphere."
- We asked staff whether they would be happy to use the service if they ever required care and support in the future. Staff told us the care provided was good but the lack of access to social activities and stimulation was of concern.
- We observed the culture to be uncaring at times, with staff showing very little empathy to people when they became distressed. For example, very little stimulation was provided on the unit for people living with dementia. We heard staff telling people to sit down when they got up out of their chair. No time was given to find out what the person wanted. A staff member told us they did not have time to chat with people.

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

- The manager told us meetings were carried out with the staff team and this was confirmed by the staff we spoke with. One staff member told us, "During meetings we exchanges views in relation to the service. We share concerns, and these are discussed and resolved."
- The manager told us 'Flash' meetings were carried out every morning. This enabled them to discuss any concerns relating to the care and support provided to people.
- The provider undertook 'resident of the day.' This meeting focused on one person each day who used the service. The meeting involved all heads of department, to ensure all the person's specific needs were met. However, during the inspection we found people's specific needs were not always catered for.
- A staff member told us people were not involved in their care planning. They said, "The manager has changed this, and people will be supported to be involved in reviewing their care."

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 understood and acted on the duty of candour.
- Discussions with the manager confirmed they were aware of the improvements required to provide a safe and effective service.

Continuous learning and improving care

- The manager told us they had identified some of the shortfalls we found during the inspection. For example, they were aware staff required training in behaviour management. They also identified the need for oral health training. They told us arrangements would be made to commission this training.
- The manager was aware of the need to continually review and assess the service and to ensure improvements were made to promote better care and support for people. Visitors and staff told us the service had improved since the appointment of the manager.

Working in partnership with others

- Discussions with the manager identified they worked with other agencies. They had recently contacted the Clinical Commissioning Group (CCG) to request an infection, prevention and control audit. This was to assist the new manager in identifying areas of improvement and to take action where 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
Treatment of disease, disorder or injury	People were not involved in decisions about their care and support. People were not supported by staff in a caring manner to meet their specific needs. Staff's approach was not caring or attentive to meet people's assessed needs. People were not supported by staff to pursue their interests. The provider had not complied with the Accessible Information Standards to ensure systems were in place to assist people to communicate their needs. People with a sensory impairment were not supported by staff to ensure they had access to their glasses and batteries for hearing aids.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	People did not receive care and support in a manner that promoted or respected their right to dignity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	Sufficient systems were not in place to support people to make decisions. Where people had capacity, they were not always involved in decisions about their care and treatment.

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
Treatment of disease, disorder or injury	Staff did not adhere to written protocols for the safe management of 'when required' medicines and this placed people at risk of receiving unnecessary treatment. We could not be sure that people received their creams as prescribed. Staff did not following information in risk assessments to ensure people were supported with their mobility safely. Staff did not have the skills to assist people to manage their behaviour safely.

The enforcement action we took:

A warning notice was issued to the provider for the breach of regulation 12.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	At the time of the inspection the manager had not registered with us. The provider's governance was ineffective to review, assess, monitor and improve the service provided to people. The provider had not taken sufficient action to comply with regulations to ensure people received a safe and effective service.

The enforcement action we took:

The provider has been issued a warning notice for the breach of regulation 17.