Hazeldell Ltd

The Willows

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
The Willows is a residential care home providing personal care for up to 66 older people. At the time of our inspection there were 52 people using the service, the majority were living with dementia. The service has three floors and people were living on each of these floors.

People's experience of using this service and what we found
Since our last inspection there had been a significant deterioration in the quality of care provided to people. This had not been promptly identified by the governance systems in place and improvements implemented, which resulted in people receiving unsafe care. We have identified a breach of regulation in this area. The operations manager and the director were open with us about the failings in the service and were committed to making improvements. The local authority were so concerned about the service, they had replaced the provider's voluntary agreement on not admitting new people to the service with their own suspension due to concerns of quality and safeguarding.

People were not being provided with a safe service. This included, people were not being protected from abuse, current risks were not promptly assessed and mitigated, and medicines were not being managed safely. We have identified breaches of regulation in relation to safeguarding people from abuse, safe care and treatment and staffing. There were shortfalls in staffing levels, which had been addressed by the provider following the first of our inspection visits. They had increased the staffing levels by 50%.

Staff were provided with training to meet people's needs. However, this training was not always effective because staff were not skilled and competent to meet people's specific needs relating to people's behaviours which may be challenging. We have identified a breach of regulation relating to staff training and competence. People's health and dietary needs were assessed; however, care records did not always reflect people's current needs and they were not always being provided with health care treatment in a timely way. People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests.

The quality of interactions between staff and people varied. Whilst we observed some caring interactions, we also observed some which were not so caring. People's rights to privacy were not always being respected.

Improvements were needed in how people's care needs were assessed, planned for and met. The operations manager was in the process of reviewing and updating people's care records. However, this was not yet fully implemented to ensure people received the person centred care they required to meet their needs. There was a varied programme of activities people could participate in. However, there was limited provision for people who chose not to participate in group activities. We have identified a breach of regulation relating to the provision of person centred care. There was a complaints procedure in place. We had received concerns prior to our inspection these were not always being acted on. The operations

manager was making improvements in this area.

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

Rating at last inspection
The last rating for this service was good (published 21 November 2018).

Why we inspected
The inspection was prompted in part due to concerns received about the management of medicines, people's safety and the care they were provided with. A decision was made for us to inspect and examine those risks. We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

The provider has taken action to mitigate the risks, this includes increasing staffing levels and planning training for staff. In addition, the local authority are working with the service to encourage improvement. The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection.

Enforcement
We have identified breaches in relation to safe care and treatment including medicines management, safeguarding people from abuse, person centred care, staffing including training and support provided to staff and how the service is managed at this inspection.

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

Follow up
We will request an action plan for 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.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate

The Willows

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
This inspection was undertaken by an inspector, an assistant inspector and an Expert by Experience on 13 January 2020. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day, 14 January 2020, the inspection was completed by one inspector.

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

The service did not have a manager registered with the Care Quality Commission. Registered managers are legally responsible for how the service is run and for the quality and safety of the care provided. A manager had started working in the service the week before our inspection, following our inspection we were advised they no longer worked in the service.

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, this includes from staff who are or have worked in the service and members of the public, such as the relatives of people who had lived or were living in the service. We sought feedback from the local authority and professionals who work with the service. We also sought feedback from Healthwatch which is an independent consumer champion

that gathers and represents the views of the public about health and social care services in England. 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 13 people who used the service and four relatives about their experience of the care provided. We spoke with 15 members of staff including a director, the manager, senior care staff, care staff, activities staff, catering staff, maintenance staff, laundry staff and the operations manager who is the nominated individual. A nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke briefly with a visiting health professional and a visitor.

We reviewed a range of records. This included five people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision and a variety of records relating to the management of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with a commissioner and a social care professional and attended a meeting with the local authority.

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.

Systems and processes to safeguard people from the risk of abuse

● The systems designed to safeguard people from abuse were not robust to ensure people were protected from abuse. We received mixed views from people about if they felt safe in the service. One person said, "Well I think so, I've got the key to my room and I lock my door at night."

● Another person told us they felt safer since they had moved floors, as they had been assaulted by another person using the service. They said, "Much better up here it is safer, [other person] set about me downstairs, twisting my arms… [Other person] used to come into my room about half past five in the morning, I did not feel safe. Much better here I feel safe now, can be in peace… Moved me up here to get away from [other person]." This clearly still affected the person because it was the first thing they told us about when we asked if we could speak with them.

● We checked this person's care plan, which still had the room number they had previously been in. The care plans and risk assessments had not been updated since April 2019, despite the records showing the next review was to be done in November 2019. There was no reference in the care plans or risk assessments to show what had happened, how it affected the person and any support to be provided to the person.

● There was an incident form in their records which identified the assault had happened in November 2019, there was no information how this had been followed up and there was no information in the care plan as to how this person was to be protected.

● In addition, we reviewed the care records of the person who had assaulted this person, other people and staff in the service. This person was assessed as low dependency. Their care plan relating to their behaviours completed in October 2019 stated the person had, "Never been physically aggressive with anyone but have been verbally aggressive to other residents." This information was also included in the wellbeing and mental health section. Reviews in November and December 2019 stated there were no changes, this was despite incidents of physical aggression to a person in November 2019 and information we had received in September 2019 about this person assaulting another.

● Concerns we had received prior to our inspection included people not being safe in the service. This supported our findings. Safeguarding referrals had not been raised with the local authority when required and plans were not effective to reduce risks to people. An example of this was there had been incidents the weekend prior to our inspection and on the first day of our inspection, due to a person's physical aggression. Despite this, on the first day of our inspection there had been no actions taken other than contacting other professionals. On the second day of our inspection, staffing levels had increased. We were advised by the local authority following our inspection visits, following their guidance, safety management systems had been introduced for this person, including regular monitoring observations. The service had not identified this independently to reduce the risks to people.

Systems were either not in place or robust enough to demonstrate people were protected from abuse. This

placed people at risk of harm. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

● The systems for assessing and mitigating risks to people were not robust enough to ensure they were always provided with safe care. Risk assessments were not being reviewed appropriately when people were at risk, for example one person's records stated they were at risk of developing pressure ulcers, their records had not been reviewed since November 2019, in addition the records stated the person was at low risk of falls but also stated the person, "Has no balance relating to condition and could fall." The lack of appropriate guidance for staff, including agency staff, could result in the person receiving care and support which put them at risk.

● One person's care plan showed they had variable mobility and sometimes required the use of a hoist and wheelchair and required the support of one to two staff. The care plan and risk assessment had been completed in June 2019 and not reviewed since. An undated 'falls prevention coordinator referral form' showed the person had six falls between 1 October 2019 and 29 November 2019. This was also the case for other risk assessments which were not reviewed regularly to show how the person was being supported with their increasing sensory loss and how this affected their daily living.

● One person's records included an assessment undertaken following a health care appointment in October 2019. A staff member had been sent to the appointment with the person, who did not usually work with them, so they were unable to share requested information relating to falls. The document stated the person was wearing inappropriate backless slippers because their other footwear had been put through the wash and the soles had fallen off. This demonstrated the service had not ensured the person was receiving safe care to reduce risks.

● In one bathroom on the first floor there were approximately 10 bottles of shampoo, conditioner and shower gel. These were a risk of people living with dementia accidently drinking them.

● A maintenance meeting had been held in December 2019, the minutes stated the fire procedures were being reviewed. At the end of the second day of our inspection visits, the fire alarm sounded. Staff arrived at the fire panel and staff were coordinated appropriately to locate the source. However, people were admitted into the service by staff, including a person delivering medicines, a relative and the manager who had been out. On the manager's arrival they told staff to enter the service as people may be distressed by the sound of the bells. However, they had not given directions on who went where, and they had not asked the permission of the individual who was coordinating. The maintenance staff member had to be called into the service, when they had finished work, to silence the alarm, as it was found there was no fire. We suggested to the operations manager the procedure for what was expected of staff when fire bells sounded be revisited, because towards the end this had become chaotic.

● There were some issues identified relating to health and safety, including the lack of risk assessments relating to working at height and using specific equipment. There was also a fire door for which the key could not be located. The local authority were visiting the service on the second day of our inspection visit to review health and safety and an additional visit resulted in recommendations provided to the service to improve the health and safety.

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

● Wardrobes in people's bedrooms were attached to the wall to prevent them falling on people and windows had limited opening to reduce the risks of people falling out of them. We looked at three walking frames, all had appropriate ferules (rubber at the bottom of the frames to prevent slipping).

● We checked a piece of equipment used to support people with their mobility, this held a sticker stating it had been serviced and the next was due November 2020.

Staffing and recruitment

● People who were in their bedrooms had their call bells within reach. However, they told us they felt call bells were not answered promptly. One person said, "I can't walk so I rely on them and they can take a long time to answer the bell if they're busy." They also said staff did not let them know if they were busy and would respond once they had finished. Another person told us, "I don't have to wait long, but then at times I do."

● People told us they felt the service did not have enough staff. One person said, "Definitely short staffed much of the time." Another person commented, "I think they rush quite often. Well I understand they have lots of people to look after but I feel a little anxious if they've not got enough time for me." One person's relative said they felt their family member was. "Well looked after, apart from staffing at times… All staff very good, all polite, it is the number of them, sometimes can't find anyone." One visiting health professional told us, "Sometimes staff are not around."

● This was confirmed by our observations on the first day of our inspection visits. There were periods when staff were not visible in the service, which was particularly important given the recent challenges relating to behaviours which put other people at risk of harm. In addition, the incorrect dependency levels identified in one person's care records, which was rated as low, when it was clearly high meant the methods for ensuring there were enough staff to meet people's needs safely were not always robust.

● Allocation of staff required improvement, for example staff had their shifts split between floors. On the first day of our inspection visit, we saw staff were unsure where they were working and what they needed to do. One staff member was told by a senior to go to another floor, despite the staff member saying they had not finished their tasks, such as cleaning up the kitchen area on the floor they were working on. The next staff that arrived then reported to the senior the jobs had not been done. Staff said they felt working for the full day on one floor would be better and improve consistency.

There were insufficient staff working in the service to ensure people had their needs met and they were kept safe. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The operations manager told us there were five day care staff vacancies and agency staff were being used to cover until staff were recruited to the posts. The operations manager told us there had been a turnover of staff, some leaving of their own volition and some after disciplinary action had been taken. Sickness had been an issue, but the operations manager told us this was improving and there had been a system introduced to monitor staff sickness.

● On the second day of our inspection we were told the staffing levels throughout the service had been increased by 50%. This was confirmed in our observations and comments made by staff. This included the use of agency staff. However, we were concerned this decision had not been made sooner given the issues regarding people's behaviours and shortfalls in the care provided.

● The records for staff recruitment did not show the systems were robust. For example, although there was evidence that disclosure and barring service (DBS) checks had been made, but there was no date on two of the records seen of when the DBS was received to demonstrate checks on any staff convictions were done prior to them working in the service. None of the records seen identified if the DBS check had been clear or if there were any convictions that needed following up. There were gaps in employment history and this had not been recorded as followed up by the individuals undertaking the interviews. There were copies of identification, but there was no written confirmation that the originals had been seen and when. The operations manager told us where there were concerns, such as with DBS checks, these would be redone.

Using medicines safely

● The systems for providing people with their medicines were unsafe. This had been identified by the service and in a recent external review of their medicine's management. This included findings that people were not receiving their medicines when they needed them. The operations manager told us they were confident improvements could be made in the safe management of medicines and they were working with the Clinical Commissioning Group (CCG) medicines optimisation team to do this.

● The manager told us they had identified discrepancies in the stock balance and recording of medicines which requires specific storage and documentation. They were planning to visit the GP surgery, pharmacy and checking in the service to see if these could be reconciled. The service had raised a safeguarding referral and notified us of the discrepancies in the medicines.

● We reviewed the controlled drug register on one floor of the service and the manager's findings were confirmed. In addition, there were records which had balances marked out with pen and overwritten. We spoke with the operations manager regarding if errors were made, these should have a line put through them and an explanation to show why it had been changed.

● We found gaps in the recording of the temperatures of medicines storage, this meant staff were not checking medicines were stored at the recommended temperature to ensure effectiveness.

● People told us there were times when their medicines had not been provided when they needed them. One person said, "They hand out the medication. A while ago they forgot to give me my [named medicine]; I have it once a week, early on Sunday morning. Eventually I rang and asked why I hadn't had it. The [staff member] was very apologetic; [they] said [they had] forgotten." We looked at this person's care records and there was no reference about the times the person needed to take their medicine or other guidance for staff about times required between taking the medicines and eating food required for example.

● Another person's care plan was contradictory relating to the support the person needed with their medicines due to their sensory loss. On the same page it stated, "Due to my poor eyesight at times may ask carer what my tablets are for as I am unable to see them if they are small." On the next paragraph it stated, "I trust staff brining me my medication and never ask what they are for." Another person told us how they had not had their eye drops, they were not sure why but thought it was because they had run out.

● One person's care records held a skin assessment completed in June 2019 stating the person does not use creams, however, there was a medicines topical daily chart dated 13 December 2019 showing the person used a gel for external use.

● One person told us how they had used their call bell because they needed their inhaler, they had told the staff when they responded to their call bell, "It took them so long to get my puffer." They told us how they had relaxed themselves and controlled their breathing as they were worried about the outcome of not receiving their inhaler promptly.

The management of medicines was not safe. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

● The operations manager told us how there had been a high number of people falling. The falls were now being analysed, checked for trends, systems developed to reduce them, and staff had been advised of their responsibilities in reducing falls. They said falls had reduced in recent months, this was confirmed in records. In addition, the operations manager told us falls training for staff was booked for January 2020 and referrals had been made with other professionals to seek advice and guidance for those people regularly falling.

● Disciplinary action had been taken when required and referrals made to the DBS, where required.

● However, there was no cohesive way of managing and assessing incidents and accidents, safeguarding

issues and concerns. There had been little action taken to safeguard people from potential abuse from other people in the service. Some of this could be attributed to the lack of action taken and recording by the previous registered manager.

● Safeguarding concerns were not being analysed and checked for trends to reduce future risks, the operations manager told us they would do this, including lessons learned.

Preventing and controlling infection

● We saw staff used appropriate personal protective equipment (PPE), such as disposable gloves and aprons to reduce the risks of cross infection. Staff wore hair nets when serving food, these were also offered to people when they were preparing food for an activity, much to people's amusement. There were regularly dispersed hand sanitisers and notices to encourage their use.

● Prior to people eating their meals and taking part in preparation for food for activities, they were provided with wipes to clean their hands.

● The service was visibly clean.

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 good. At this inspection this key question has now deteriorated to requires improvement. 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 were not always skilled in supporting people with their behaviours which others may find challenging. Whilst we were speaking with a person and their relative in the person's bedroom, a staff member came in, without knocking, and locked the door. They explained a person was being aggressive and they were, "Not staying out there." They left after approximately a minute. This demonstrated the lack of confidence and skills to support people when they were displaying behaviours others may find challenging. We spoke with the operations manager and the director about what we had seen, and they said they would look into additional training to assist staff with their confidence and skills.
- One staff member told us about how the service supported people when individuals demonstrated behaviours that others may find challenging. They said the seniors supported the carers. They said they would like more training or to get staff in room to talk about how they would manage. Staff had received training in communication, interaction and behaviour and dementia. However, we observed varying quality of care provided to people, which demonstrated staff were not always competent and confident when supporting people with distress reactions relating to their complex needs. Despite behaviours which may be challenging happening in the service, the provider had not taken swift action to ensure staff had the skills to support people safely.
- Staff records reviewed included induction forms which showed they were shown around the building and completed shadow shifts with more experienced staff. Training forms were not completed to demonstrate how the training had been incorporated into their induction, including checking their competency after training. Staff's views about if they had received an induction varied. One staff member said they had an induction which consisted of being shown round building and three shadow shifts, which they said was, "Amazing," and they continued to receive support. Another said they had not really had that much of induction. They stated they felt, "Like being in swimming pool paddling and fluffing round in the shallow end and I can see everyone else doing what they should be doing but not knowing how to get over to them."
- The operations manager told us supervisions for staff had not been in place, there was a plan to ensure these were provided to staff to support them to discuss their work practice, receive feedback and identify any training needs. Staff's comments about if they felt supported varied, some said they did not feel supported by senior staff and management but others did.

Staff were not always confident and skilled to meet the complex needs of the people using the service. Staff had not been provided with suitable supervision to enable them to discuss their work, receive feedback and identify further training needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There was a training record in place which showed the staff training, this included moving and handling, end of life care, and equality. One staff member told us most of the training was done online, apart from the moving and handling which was done face to face. Further face to face training was booked for the month of our inspection visits, this included moving and handling, medicines and falls training. This was confirmed by other staff who told us they were looking forward to the face to face training.
● One person's relative told us about if the staff had the skills to meet their family member's needs, "Most do but some of the younger ones do not, so they work with more experienced staff while they're learning, and I suppose that's reasonable."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Prior to moving into the service people's needs were assessed. However, we found this was not always done in an effective way. For example, one person's care records throughout was contradictory relating to if the person was living with dementia, in addition, details of the medical history had not been obtained prior to them moving in, which is very important to ensure they received the right care and treatment.

Supporting people to eat and drink enough to maintain a balanced diet
● People's views about the food they received were varied. One person said, "It's okay. They come and ask what I want in the morning, there's normally a choice." Another person said, "It's not really very good much of the time." One person told us, "I can't eat prawns, I'm allergic to them so if it's fish I always ask, and they'll give me something else instead." We asked if staff were aware of this and the person responded, "Well they should by now, but I still always ask, just in case." We checked the person's care plan and the allergy was not included.
● The way people were served with their meals and attentiveness from staff varied. Some staff spoke with people when they delivered their meal, whilst others put the plate on the table and walked away without speaking. People were variably offered encouragement by staff to eat. Some staff asked for permission to remove people's plates and if they had finished their meal and some did not.
● On one floor, lunch was delivered in a hot trolley and gravy was supplied in a large jug, only one staff member went to one person to ask if they wanted gravy on their meal. All the rest of the meals, staff poured the gravy onto the plate before serving to the person.
● Choices of hot and cold drinks were offered to people throughout our inspection visits. People who were in their bedrooms had drinks, but these were not always within their reach. For example, one person who told us they could not mobilise independently their drink was not in their reach. Whilst we were talking with a person in their bedroom a staff member provided their choice of hot drink, put it down out of their reach, asking if it was okay there and left.
● One staff member showed us a new form for meal ordering. People were colour coded to show if they required a specific diet. The staff member said this was an improvement and had been in use for couple of months. They told us people had a choice of meals and if they did not like the menu choice then they would be provided with something else.
● We spoke with a member of the catering staff, they were able to tell us about the provision of, for example, fortified and high calorie food and drinks to support people to maintain a healthy weight and provide deserts suitable for people who required a diabetic diet. They told us they had a board in the kitchen which identified people's specific needs.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People's comments varied about if they had access to health care professionals when they needed them. One person told us, "A few days ago one of my teeth broke, ooh I was in pain. The staff tried and tried to get an emergency appointment for me, all afternoon and into the evening they tried but, do you know what,

there isn't an emergency dentist anywhere round here. I still haven't got an appointment but at least it's stopped hurting." We checked this person's care records, which included an undated mouth care assessment which stated the person did not need a dental appointment.

● During our inspection visit we saw a chiropodist visiting people in their bedrooms, one person told us they visited every six weeks. The local GP surgery visited the service weekly to ensure any concerns with people's health could be monitored.

● People's care records included mouth care assessments, which identified if the person could use a toothbrush and toothpaste, brand of toothpaste, if the person had dentures, when they were worn and where they were kept when not wearing. These assessments did not have an associated care plan which guided staff on the specific support people needed with their oral care.

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.

● People's views varied about if they felt the staff asked for their consent before providing any care. One person said, "I don't really feel involved, they just seem to get on and do whatever they need to." Another person told us, "I've thought about this quite a lot; people have an idea in their heads about what care homes are like and mine was correct. It's like a prison. I cannot get out; the doors are locked and even if I want to go [to visit their friend on another floor in the service or go to other floors] someone has to be with me, so I can use the lift. I did manage quite well when I was living on my own." We did see other people using the lift during our inspection visits.

● People's care plans were confusing if people had capacity or not, for example, one person had said they wanted their family involved in their care and their relative had signed the forms to consent to care, there was no reference if this person had the authority to do so and if the person had a condition which affected their decisions. There was a record relating to best interest decisions and capacity relating to their care needs completed in June 2019 which stated the person had no impairment of mind, but further records in December 2019 stated they did but there was no indication of what the impairment was.

● Another person had signed their records to state they consented to care and treatment but there were MCA forms stating they did not have capacity to make decisions.

● The operations manager told us they had made DoLS referrals, where required. They were in the process of reviewing people's care records and updating the records relating to people's capacity to ensure they were clear. This was confirmed in one of the care records which had been reviewed.

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

● The building was a large, purpose-built structure with accommodation over three floors. There were two lifts and five stairwells granting access between the floors. Access to stairs and lifts was restricted by means of keypads. It was possible for someone to walk round floors if they wished. One person told us they liked to exercise and was able to would walk on the floor they lived on, which was a routine they followed.

● On each floor there was a lounge/dining area together with other communal rooms where people could sit quietly. For example, on the ground floor there was a room designated as 'the library' where a singing activity was held in the morning. There was a quiet lounge with no television, a café style room and places in the corridor which widened out a little and had two or three armchairs, so people could sit. There was also a room in the service which people used as a cinema.

● Corridors were all wide and level with hand rails on each side. Private bedrooms were numbered and most had a photograph of the occupier together with their name. The operations manager told us people chose if they wanted to have a photograph on their door.

● There were clearly signed communal toilets and bathrooms. One was out of order with a sign on the door saying it was not to be used. The operations manager told us a part had been purchased and it was due to be repaired. People's bedrooms also had en-suite facilities.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- People's comments varied about if they felt the staff were caring and kind. One person said, "Not always no… there will be two carers and they'll talk about their private lives, about things which are really inappropriate." When I've said something they just make a joke of it, like it was nothing." This person also said they felt, "As though I'm less important, that I don't matter." Another person said, "I think they do their best, they're very good." Another stated, "They aren't unkind, they just seem quite busy." Another stated, "I think they are very kind and caring, I can't fault them."
- There were varying standards of interaction from staff toward a person who requested staff attention. Some were very good, they were calm and spoke with the person gently, one staff member stroked the person's hair. However, others were not so caring, some staff sidestepped the person with no eye contact, others peeled the person's hands off them and others attempted to support the person, which resulted in them continuously telling the person they were hurting them. One staff member referred to themselves in the third person which may be confusing for a person living with dementia. Another staff member said, "I am busy," they were completing records on their hand held device, the person held onto their arm and the staff member said loudly and harshly, "I am busy," they then quickly changed their tone and spoke with the person in a gentler manner.
- A staff member was walking with a person holding their hand, they handed this person over to another staff member saying, "I need to make a couple of telephone calls." At no point did the staff member explain to the person what they were doing and why, they just passed their hand to another member of staff.
- One person told us how they felt the staff could improve in the way they supported them, "I have limited vision, I'm unable to focus so can only make out vague shapes. I would find it useful when people come into my room if they'd say who they were. Some do but most don't."
- Despite the shortfalls observed, we also saw some good and caring interactions. This included a staff member who sat with a person supporting them to take their medicines. This was done at the person's own pace and in a person centred and caring way. The staff member was calm and patient and explained to the person what they were taking and why, they said to the person, "You have three more to take, take one at a time so you know what to take. One medication in my hand, I will place it in your hand then you will put it into your mouth, so you can swallow it, then I'll give you a drink. We will do that two more times."
- We saw one person refer to a staff member as, "My baby," and kissed them, the staff member's interaction was very caring. This person told us they liked the staff, "Very much."
- One person told us about their spiritual observance and said, "They have a service once a fortnight on Sundays. If they had one a week I'd go but I suppose that might be a bit too much to expect."

Respecting and promoting people's privacy, dignity and independence

● People's comments varied relating to if they felt the staff respected their privacy. One person said, "Well certainly not all of them do. Most just come into my room when they need to, they don't knock or ask permission." Another person commented, "They don't knock or ask if it's okay to come in, they just walk straight in."

● People told us other people living in the service had gone into their bedroom, which did not respect their personal space. One person said, "There have been times when other residents come into my room and on one occasion a [person] came in and sat on that chair. I asked [the person] to leave and rang the bell. When a carer came they took [the person] away."

● There was no real attention to confidentiality, staff talked amongst themselves about support they were providing to people, which could be overheard by others. For example, one staff member called along the corridor if a person needed a hoist, and where was it, another staff member said, "We are getting [person] walking, use [person's] walker."

● One person told us how the interaction from one staff member assisted them with their independence, "At lunch they bring me my food... one carer always says to me, your potato is at 12 o clock; your peas are at 3 o clock and so on. That's really helpful. None of the others do that. I don't think they really consider my limited vision and how they could help me."

● People's care plans throughout included information for staff in how people's privacy, independence and dignity were to be promoted and respected. However, improvements were needed to ensure staff followed this guidance.

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

● The systems for asking people about their decisions about their care varied. People we spoke with said they were not aware of any regular meetings to discuss their views or knew about their care plans.

● People's care records held documents which included people's preferences, such as what their preferred form of address, how they liked their drinks, preferences of going to bed and getting up times, and anxieties and worries.

● We asked people if they felt their preferences about how they wanted to be cared for were respected. One person said, "I like a bath and I can have one anytime as long as they're not busy. I don't mind whether I have male or female carers helping me and they know I like to tidy my room and make the bed myself. They won't let me change it mind. I like to put my own things away because then I know where everything is." Another person stated, "I have a bath once a week which is alright." We asked if they could have them more often if they wanted to, they responded, "I don't think so but one's fine."

● Whilst we saw some staff respected people's choices at lunch, this varied. For example, we were talking with two people about what was on the menu, one person told us they had chosen the pie. A staff member called across the room saying the person had chosen sausages to which the person said, "Oh." There was no further discussion with the person by the staff member if this was still what they wanted or if they had changed their mind.

● One person told us they were superstitious and did not like the colour green. They said they told staff and their bedroom was painted blue, they were happy with this.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

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

● Staff were not always responsive to people and their needs. Some of the interactions and actions from staff were not responsive. For example, before lunch a person had their feet resting on a cushion. When lunch was served, a staff member removed the cushion to move the wheeled table in front of them. The person started to lean to their right and their feet were hanging in mid-air. Another staff member, after 10 minutes, asked the person if they would like to move so they were more comfortable. They encouraged the person to shuffle in the seat and sit a little straighter, their feet then rested on the table support.

● One person was on the ground floor looking for their bedroom, which was on the second floor. A care staff member took them to the lift. We saw this person on the first floor still looking for their bedroom. A care staff member told us they could not take the person to their bedroom because they were alone and not sure where staff were, they could be with someone or on breaks. We had previously walked around this floor and only saw this one member of care staff. This demonstrated the poor communication and coordination of staff. We then took the person up to their bedroom.

● We asked people if they felt the care they received was focussed on their needs. One person said, "Sometimes but it's not consistent, it all depends on the carer." Another person commented, "I think they know what care I need, and they look after me very well." Another told us, "I cannot walk so there's quite a lot they have to do for me, there's not much choice really."

● Some care plans were contradictory and did not include the most up to date information regarding people's current needs to provide guidance for staff on how to meet them. They did not explain people's conditions and how they affected them. This included one person's records which were contradictory relating to if the person was living with dementia or not. Another person's records did not identify the risks associated with behaviours others may find challenging. Records of belongings were not always completed in people's care records.

All of above demonstrated people were not always receiving personalised and responsive care. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The operations manager was working on reviewing all the care plans in the service to ensure they reflected people's individual needs. However, this was not yet fully completed.

● One staff member told us, if they were unsure about someone's care needs, they said they would speak to senior or the manager if unsure. They said they would do this more in first instance than look in care plans, but if everyone was unsure then they would look at care plan. The staff member said 'client of day' started couple of days ago and they had new allocation forms. 'Client of the day' included reviewing people records

with their input and providing any specific support they needed, for example, with food, activities and health.

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

● The service had a good programme of social activities people could participate in. However, outside of these group activities there was limited time for staff to spend with people, particularly those who chose to stay in their bedrooms. One person told us they did not like to ask staff for support such as using the lift or going into the garden in the better weather, "They are very busy, I'm not sure they have time." Another person told us they did not go to the group activities often because it was too painful for them to sit for long periods of time, so remained in their bedroom the majority of the time. They said, "No one has time to talk to me… no one comes up to spend time with me, sometimes a carer will if they have enough time." One person's relative told us their family member was a, "Loner, I would like it if they encouraged [family member] to join in more to be honest; I think [family member] might enjoy it more than [they] think."

● Staff views about if they had time to spend with people varied, this was clear the differing views depended on what floor staff were working on. One staff member working on the second floor said they had time to speak with people. Another staff member told us there was no time to sit to speak with people, they said if they did, they were made to feel like they were not working by colleagues.

People were not always receiving meaningful interactions to reduce the risks of them becoming lonely and isolated. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There was a variety of very good group activities happening during our inspection visits, including making coconut ice, tap dancing, and some local schoolchildren visited who sang with the people using the service. We went into the library following the activity and a staff member told us this was held every month and showed us a video of the people and children singing. This made people smile, one person said, "We have a nice time, they are a lovely lot, we enjoy it."

● There was a monthly activity diary, which identified the planned activities for the month and any visiting entertainers booked. There was also information from the 1920's theme of the month, a word search and a picture for people to colour in if they wanted. There was a varied range of activities offered for people to participate in. However, we noted there was only one morning a week dedicated to one to one support and the hairdresser and barber was listed as an activity.

● One staff member told us, "The activities co-ordinators, it's amazing the stuff they do. They get singers in. In summer have barbecues and visitors. Lovely to see kids and elderly. Used to have cubs coming in and they loved talking to residents about what they did on ships and during the war."

● One person showed us their nails, which had been painted by a staff member, they said, "I am very pleased with them." Another person showed us their, "Willows money," which they used to spend at the in-house shop, this included old style one pound notes.

Improving care quality in response to complaints or concerns

● People told us they had not raised a complaint but said they would speak with a senior staff member if they did.

● There was a complaints procedure in place.

● We had received concerns prior to our inspection that complaints were not being listened to and addressed. This was now being improved and we saw recent complaints were investigated and responded to and systems to reduce future risks developed.

End of life care and support

● Some records seen included people's end of life decisions, such as where they wanted to be cared for in the service and any specific requirements they had in how they wanted to be cared for at the end of their life. All of the records we reviewed included their decisions relating to if they wanted to be resuscitated.

● There was a letter in people's care records from November 2019 to people's relatives asking if they could provide any end of life decisions their family members had made. This demonstrated the service were attempting to make improvements about how they gained information about people's decisions.

● The records of one person, who was receiving end of life care in the service included end of life decisions and discussions with relatives made during their time in hospital, for which they were discharged with pre-emptive medicines. Their records included their end of life decisions completed in the service. However, the majority of the person's care plans and risk assessments had been completed in June 2019 and not reviewed to show they were now receiving end of life care and their dependency was rated as medium. This could lead to the person not receiving the care and support they required.

● Staff had received training in end of life care. One staff member told us they had end of life training on line and wanted to learn more about it.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● People's care records identified their communication needs. We were told important documents could be provided in different accessible formats if required.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Since our last inspection, we found a deterioration in the quality of care provided, this included in all of the key questions: safe, effective, caring, responsive and well-led. The shortfalls had not been identified in a timely way to prevent the deterioration in the quality of care. Although the operations manager and the director had taken disciplinary action, were aware of shortfalls in the service and committed to improving, the significant deterioration meant people were receiving unsafe care. We had received concerning information from the local authority and were told the provider had voluntarily agreed to not take any new people into the service until improvements had been made. However, we were further informed the local authority had made the decision to change this to a suspension of new admissions due to safeguarding and quality concerns.
- Since our last inspection the previous registered manager no longer worked at the service, they left in October 2019 and were deregistered in November 2019. The management of the service had been overseen by the operations manager and the head of care. The provider was actively recruiting to the manager role and a new manager started working in the service the week before our inspection. However, we were told the week following our inspection visits the manager would no longer be working in the service.
- Staff told us how they were hoping the new manager would make changes for the better. One staff member said it had been tough without a manager, although, "[Operations manager] has been great help to this place," and stated changes were happening, and the atmosphere was improving, staff were not so stressed which meant people were happier.
- All of the staff we spoke with said they loved their job and were committed to providing people with good quality care. However, comments received and concerns we had received prior to our inspection demonstrated there was low staff morale and a lack of trust in the senior and management team because they had raised concerns and did not feel listened to or valued. A staff member told us, "This was not a good place last year." They went on to tell us how they had told a member of the senior team something in confidence and another staff member had been told. They were more positive for the future.
- We were told by staff about cliques of staff who others found intimidating to work with, and allegations of bullying. We fed this back to the operations manager and director.
- One staff member described the service as, "Organised chaos." This was confirmed in our observations. Staff did not know where they were working or what they were doing. We saw one staff member ask an agency staff member what they needed to do. At one point four staff members stood around a table rather than supporting the people in the service. We saw a staff member asking senior staff where they needed to

be, "I am upstairs at 2pm shall I go?" The senior said they were waiting for handover. Some senior staff were not managing their shift, they were not providing staff with clear guidance and direction. It was not clear if the senior staff had in turn received guidance on how to ensure the smooth running of the service and meeting people's needs.

● Some people had not been supported to get up by late morning on the first of our inspection visits. We saw a staff member ask a senior if they would help them to get a person ready for the day they had already been to another floor to ask for help, the senior checked their watch and told the care staff member they needed to attend a meeting at 11.30am, which was the time. They said, "They are all safe, no wet pads, will be alright for a while." We did not check if they did help the person as requested or went to the meeting. We fed back to the operations manager about what we had observed. They said that the priority should be meeting the person's needs and attendance to the meeting could have been delayed.

● In one medicine room we found a pile of records which had not been filed, these included feedback to the service from people's health care appointments, such as recommendations made relating to a person's dietary requirements, notices of health care appointments, records of discussions with health care professionals. We told the operations manager what we had found, and they were going to check if the appointments had been logged and the recommendations had been included in people's care plans.

● The operations manager was working through people's care plans to ensure they were up to date and reflected people's needs. However, the care plans we selected to review, including a person who we had been told required end of life care, a person who had been assaulted by another person, and a person who had assaulted other people and staff, had not been reviewed, so had not been prioritised. However, we reviewed a care plan of another person who displayed behaviours that others may find challenging and found this was improved following the operations manager's review and update from the others seen. This described the potential risks and triggers to the person's anxiety and guidance for staff in how to support them.

● There was a lack of cohesion in incidents and events happening in the service to enable to management team to identify potential patterns to behaviours and safeguarding incidents. The operations manager told us they would address this.

There were significant shortfalls and deterioration in the care provided. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The operations manager was open with us about the ongoing concerns in the service and was working to implement changes. The operations manager and the director told us they were committed to improving the service. On the first day of our inspection visit the director had met with the manager and operations manager to discuss the service. Following this meeting, the staffing in the service had been raised by 50%.

● Following our last inspection, the service had provided a service for people requiring reablement support, between leaving hospital and returning home. The operations manager told us this was no longer the case since November 2019, and the service were not providing nursing care. At the time of our inspection visits they applied to have this regulated activity removed from their registration.

● We had not previously been notified of all incidents by the service. These notifications are required by law, the service must tell us of specific incidents and explain what had happened and measures in place to support people safely. Since the operations manager had been managing the service, these were now being received, as required.

● The operations manager told us about the improvements made relating to falls and how the numbers of falls were decreasing. The staff meeting minutes in December 2019 stated falls had reduced, falls training was booked for January 2020 and staff were updated relating to how to ensure sensor mats were in place.

● One staff member told us how they felt the service was improving, "Lots of changes but all changes for the good." They showed us their hand-held device where they recorded people's daily records and said these

were larger replacements, because the previous ones used were too small and had been dropped and lost, "So got more sturdy ones." One staff member told us there were not enough hand-held devices to go around the staff team, so they had to ask another care staff member to record on their behalf. The operations manager and director told us this was because they had raised the staffing levels and they would ensure there would be more available.

● A member of the catering staff told us how the team were working to improve the paperwork and running of the kitchen. They told us they felt things were improving and they had received guidance from the operations manager on what needed addressing.

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

● Quality assurance surveys had been carried out in November 2019 for people who used the service, seven people had completed them. An action plan was developed which identified they were planning to increase the feedback received. Feedback had also been received from five relatives, as a result of comments received the service were reviewing cleaning schedules, had replaced flooring in one bedroom, and the rota was to be reviewed. We found this had been ineffective because people continued to say there were not enough staff and this is what we found.

● A member of the catering staff told us they received feedback from the menu and food from the people who used the service, they said they asked if they enjoyed the food to know if any changes to the menu were needed.

● Staff surveys had been completed in November 2019, 11 had been received. As a result of comments daily head of meetings had been implemented, full training and shadow shifts being developed and face to face training planned.

● Staff meeting minutes showed they were being updated in areas that needed improving. For example, the meeting with catering staff in January 2020 stated staff must improve in the documenting of cleaning and the provision of any fortified foods and drinks. The minutes from a staff meeting in December 2019 showed discussions took place relating to errors with medicines and training was booked for January 2020.

● The minutes of a staff meeting identified staff had said they did not feel involved in the running of the home and as a result an agenda had been posted to allow staff to add items they wanted to be discussed. The issues of staff divide, and bullying was discussed, and stated that bullying allegations could be discussed separately, this did not fully resolve the matter, but it was stated team building would be held early in 2020, they would be developing a suggestion box, operating an open door policy and improving the interview processes for promotion. This was evident because staff had raised concerns with us during our inspection visits. The operations manager and manager told us they were planning to provide all staff with a code of conduct and planning group supervisions to improve.

Working in partnership with others

● The operations manager to us they had attended a local authority safeguarding strategy meeting the week before our inspection visit. They updated us with concerns raised, including shortfalls with medicines, high number of falls, and safeguarding concerns raised. They told us the commissioners were heavily involved in the service and an action plan was in place to implement improvements. This was confirmed by feedback received from the local authority.

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 operations manager had written to people's relatives in line with their duty of candour procedure relating to a recent incident where people had not received their medicines.

● We also saw a letter completed in line with the duty of candour procedure relating to a complaint

received.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not always receiving personalised and responsive care. Regulation 9 (1) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people using the service were not appropriately assessed, reviewed and mitigated to protect people from avoidable harm. The medicines management in the service were not safe. Regulation 12 (1) (2) (a) (b) (d) (f) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The systems to keep people who use the service safe from abuse were not robust. Regulation 13 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's governance systems were not

robust enough to identify the failing in the service in a timely way to prevent people using the service from receiving unsafe care.

Regulation 17 (1) (2) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient staff to ensure the needs of the people using the service were met promptly. Staff were not always skilled and confident to support people with behaviours others may find challenging. Staff did not receive appropriate supervision. Regulation 18 (1) (2) (a)