A.V. Atkinson (Fourways) Ltd

Fourways Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Fourways Residential Home is a care home providing personal care to 16 people aged 65 and over at the time of the inspection. The service can support up to 20 people in one adapted building split over two floors.

People's experience of using this service and what we found
People did not always receive their medicines as prescribed. Staff were not assessed as competent to administer medicines. Risks were not always assessed, monitored or managed safely and effectively. Accidents and incidents were not sufficiently recorded or investigated. People and health professionals did not always feel there was enough staff on duty. Records and observations confirmed this. There was not always evidence to show how lessons learned were shared and used to make improvements. Staff wore appropriate personal protective equipment. The home was free of malodour with a designated staff member cleaning the home. Staff recruitment checks were undertaken to ensure that they were suitable and safe to work with people made vulnerable by their circumstances. People told us they felt safe in the company of staff.

Staff were not in receipt of adequate training and support to meet people's needs. People's needs were not always identified through a robust assessment of needs and care plans lacked detail, which meant staff did not have access to clear information about how to support people safely and meet their needs. The decoration and some of the fabric of the building was in poor condition and some elements of the premises required action to be taken such as no hot water from the shower room tap and damp stained carpets. People were not always supported to have maximum choice and control of their lives and staff did not always support them in a way which met the Mental Capacity Act (MCA). Consent to care and treatment and best interest decisions had not always been obtained in line with legislation and guidance, such as the MCA.. The registered person was depriving people of their liberty without legal authority to do so. People were very positive about the food. People's individual nutrition and hydration needs were being met.

People were not always supported to make decisions about their care. Some aspects of care delivery did not ensure people's privacy was maintained and dignity upheld. People and relatives told us they felt staff were kind and caring. Staff were respectful and warm when they spoke about people. We observed kind and caring interactions. We have made a recommendation about privacy, dignity and respect.

People did not always receive individualised care which met their needs and preferences. For example, people had specific 'bath days' each week. People's individual preferences on how they wished to spend their time had not always been explored and people felt they were not always met. People's care plans did not always contain sufficient information about the care and support they required. There were not always completed plans in place to support people at the end of their lives. Complaints had been dealt with appropriately. People and relatives knew how to complain and felt action would be taken by the management team.

There was no registered manager in post at the time of inspection. The provider failed to identify and manage risks appropriately and did not ensure a person-centred approach was in place. Audits were not sufficiently robust and the registered person failed to have effective oversight of the service. The provider did not always ensure Duty of candour. The provider conducted surveys to get feedback about the service. Residents meetings had recently been introduced for people to provide feedback. We saw evidence that staff worked in partnership with other professionals.

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

Rating at last inspection (and update)
The last rating for this service was Requires Improvement (published 5 April 2019). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about infection control, staffing, allegations of abuse, poor management and risks to people not being mitigated or managed. 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 detailed sections of the full report.

Enforcement
We have identified breaches in relation to person-centred care, medicines management, staffing, assessing, mitigating and managing risk, consent to care and treatment, deprivation of liberty safeguards, premises, governance, duty of candour, notifiable incidents and the registration condition to have a manager registered with CQC.

We are mindful of the impact of Covid-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

Follow up
We have requested an action plan from the provider and we will have regular meetings with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as soon as CQC reverts to undertaking routine inspections. However, if absolutely necessary CQC will give consideration to the use of inspection and enforcement powers where we have concerns of harm.

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 of 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 re-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

Fourways Residential Home

Detailed findings

Background to this inspection

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

Inspection team
This inspection was carried out by one inspector, an inspection manager, a nurse specialist advisor and an Expert by Experience (ExE). An ExE is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Fourways Residential Home 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. The current manager was unavailable during the inspection so we were supported by the acting manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. 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 to 16 people who use the service and two relatives about their experience of the care provided. We spoke to seven members of staff including the acting manager, care staff, chef, housekeeper and the nominated individual. The nominated individual is also the only director of the provider company.

We observed people's dining experience at lunchtime. We observed people being administered their medicines. We reviewed a range of records. These included eight people's care records and multiple medicine records. We looked at three staff files in relation to recruitment and staff supervision. We looked at a variety of records relating to the management of the service, including policies and procedures, accidents and incidents, complaints, audits and quality assurance records were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with four professionals who regularly visit the service.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

At the last inspection the registered provider had failed to ensure the proper and safe management of medicines. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and this was a continued breach Regulation 12 for the unsafe management of medicines.

- People did not always receive their medicines as prescribed. For example, one person was prescribed a medicine that should be administered at the same time each day. However, this person did not received their medicine at the time indicated on the medicine administration record (MAR), as prescribed. We discussed this with the acting manager and nominated individual who confirmed that they did not have a staff member on duty trained to administer medicines at the time specified on the MAR.
- We reviewed an incident which took place in January 2020, where a person had a fall during the evening. The person had expressed that they were in pain, however, staff on duty were not trained to administer medicines. No other action was taken by the staff on duty to enable the person to have pain relief. This meant the person remained in pain until day staff arrived 11 hours later, who were trained to administer medicines and did so.
- Staff were not assessed as competent to administer medicines in line with national guidelines and best practice. National guidance states that social care providers should ensure staff have an annual review of their knowledge, skills and competencies. However, we found that staff had not had their knowledge, skills or competency reviewed as expected, to ensure they were able to administer medicines safely.
- Best practice sets out that each person should have a front page for their MAR that displays a photo of the person and any important information such as allergies they may have. This enabled staff to ensure they gave the medicine to the correct person and in a safe way. However, we found one person did not have a front page.

Failure to ensure the proper and safe management of medicines is a continued breach of Regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following the inspection the nominated individual advised that they would ensure all staff were trained and competency assessed in medicine management.
- Medicines had been stored appropriately in a locked trolley and in the homes designated clinical room.

● Guidance was in place for staff to follow for as required medicines.
● Staff regularly monitored and recorded temperatures where medicines were kept ensuring they were stored safely.

Assessing risk, safety monitoring and management; learning lessons when things go wrong

At the last inspection we found the registered provider had failed to suitably assess and mitigate risks to people. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement was made and the provider was still in breach of Regulation 12 for failing to assess, mitigate and manage risks to people.

● One person was prescribed a medicine which thinned their blood. There was no guidance for staff to follow on the risks to the person of taking this medicine. There are a number of risks to people when taking blood thinning medicines. Those risks include avoiding certain foods, drinks and over the counter medicines, excessive bleeding as a result of an accident or incident and potential adverse reactions when taken with certain other medicines. These risks could lead to symptoms people can present with which staff would need to monitor for. The lack of suitable guidance and risk assessments meant that staff did not have all information available to them to mitigate and prevent such risks which could cause this person harm.
● Another person had recently had an oral infection. However, there was no risk assessment or guidance in place for staff on preventing this from reoccurring. It had been recognised that this person was at risk of a repeat infection and their care records stated that they needed assistance with their oral hygiene. However, records showed they had not received oral care for three days at the time of our inspection.
● A person fell and fractured their hip and showed symptoms of being in pain. Following this incident, staff failed to seek medical attention for 11 hours or take appropriate action to mitigate or manage the risk of this person being in pain. The provider had also failed to notify the local authority, as required, of this serious injury.
● Another person had suffered from seizures historically and they were prescribed epilepsy medicines to reduce the incidents of seizures, which the staff supported them to administer. However, there was no care plan or risk assessment in place to provide guidance to staff on what to do in the event of the person having a seizure. There was no guidance in place to identify signs this person may present with or what staff should look out for. No staff had training in working with people with epilepsy.
● There was no evidence that action had been taken to mitigate the risks we identified during the inspection. For example, we found that there still were no staff on duty on the night shift who could administer medicines to people should they require it. The nominated individual could not evidence that they had shared lessons learnt with staff from the incident where a person fell and sustained a fracture. There was no recorded evidence that the staff supporting the person at the time knew the appropriate action to take to manage risks relating to people falling and/or presenting with pain.

Failing to ensure care and treatment was delivered in a safe way. Risks to people were not always assessed, mitigated and managed in a safe way is a continued breach of Regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
● Following the inspection the nominated individual advised that they would implementing new guidance for staff on what action to take if a person should fall.
● People had appropriate evacuation plans in place in the event of an emergency.
● Equipment was tested regularly including alarms, firefighting equipment and emergency lighting.
● Risk assessments were in place for some people such as risks relating to pressure sores. Where a person

had a pressure sore staff were providing the right support and care and working closely with the district nurse.

Staffing and recruitment

At the last inspection we found that the provide had failed to deploy sufficient numbers of suitably qualified staff. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found the provider had not made enough improvement and this there was a continued breach of Regulation 18 for failing to deploy sufficient numbers of suitably qualified staff.

● The provider failed to ensure sufficient numbers of suitably qualified and competent staff were deployed to meet people's needs in a safe way. During the inspection we found that staff were not rostered in for the night shift who were trained to administer medicines. This meant people didn't receive their medicines as prescribed or when needed.
● The nominated individual told us that there should be three members of care staff on duty in the day to meet people's needs. We looked at the staff rota's that were in place and found that this was not always the case. For example, on 18, 25, 26 and 28 January 2020 and 1 and 2 February 2020 there were only two care staff rostered to work. We discussed this with the nominated individual who did not provide evidence that enough staff were working to meet the fundamental standards.
● The provider was not able to demonstrate that an effective system was in place to ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed at all times to meet the needs of people and ensure their safety. For example, where only three care staff were rostered during the day, where people required two carers to support them with their personal care or mobilising, this meant that there would only be one member of care staff to support the remaining 15 people living in the home.
● The rotas we reviewed identified that there were regularly no cleaning staff rostered to undertake that role on the weekends. This meant care staff would be expected to complete these cleaning tasks, further reducing the care hours available to support people.
● The nominated individual told us they expected the manager and deputy manager to undertake care hours when required. However, this meant they would not be able to focus on the management of the service and have sufficient oversight of the home.
● Care staff were expected to take on the extra role of undertaking social activities with people. During the inspection there were four care staff on duty. We were told that one care staff member was called after we arrived and asked to come to the home as, "CQC is here." We noted after lunch one care staff member was doing a ball game activity with a person. If the additional care staff member had not been called, this would have left only two care staff remaining. If a person requiring two care staff needed to support a person with their personal care, there would be no care staff to support the remaining 14 people.
● One person told us that they felt there was enough staff but they often had to wait for care. They said, "Sometimes you have to wait if they are busy."
● A staff member told us they felt that there could be more staff to support the home. They said about their role without that support, "It is hard work."

Failing to ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed to meet people's needs is a continued breach of Regulation 18 (Staffing) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider operated a safe recruitment procedure which helped to ensure only staff who were suitable to work with people living at the service were employed.
● A relative told us they thought there were enough staff when they visited. They said, "There's always someone here when she [loved one] needs them."

Systems and processes to safeguard people from the risk of abuse
● We noted from people's care plans and, from talking to both staff and people using the service, that some people did not have appropriate DoLS authorisations in place but were assessed as not being able to safely leave the home without support from staff. This meant that people were being deprived of their liberty without lawful authority.
● One person who had been living in the home since 2017 had previously had a DoLS authorisation in place as the home and the local authority had assessed them as not having capacity to make certain decisions and they were not able to leave the home independently. This DoLS authorisation had expired in 2018. We looked at a mental capacity assessment for this person which had been completed in February 2020 which stated the person was still not safe to leave the home on their own and staff should not give them the key codes to get out. Where the mental capacity assessment required the staff member to record whether DoLS was applicable, "Not applicable" was ticked. The provider had failed to reapply for a DoLS authorisation for this person despite documentation that the person should continue to be deprived of their liberty.
● A health social care professional felt that the management had, "Limited understanding around DoLS and when the home need to apply."

Failing to ensure people were not deprived of their liberty without lawful authority 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.
● People told us they felt safe in the home. One person said, "I definitely feel safe here. It's like a big family."
● Staff we spoke with knew how to recognise abuse and what actions to take if they felt people were at risk of harm. One staff member told us, "If I saw something worrying I would report it to the manager or the local authority safeguarding team."
● Staff were trained in the safeguarding of vulnerable adults. There was a relaxed atmosphere at the home. People sought out staff's company and were observed being comfortable in their presence.
Preventing and controlling infection

At the last inspection we found the registered provider had failed to ensure measures were in place for the prevention and control of infection. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection enough improvement had been made and the registered provider was no longer in breach of Regulation 12 in relation to the prevention and control of infections.

● The home was free of malodour. We observed a designated member of staff cleaning the home.
● Staff were provided with personal protective equipment (PPE), so they could carry out their work safely. We observed staff using PPE appropriately during the course of our inspection.
● Staff had completed training in infection control and knew how to ensure people were kept safe through the prevention and control of infection.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

At the last inspection we found that people were supported by staff who had not completed training required by the provider to safely and effectively carry out their duties. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found the provider had not made enough improvement and this was a continued breach of Regulation 18 for staff training, skills and experience.

- We were provided with a training matrix during the inspection which we were informed had up to date information on what training staff had completed. This evidenced that staff had completed training that the provider deemed mandatory, such as safeguarding, fire training, dementia care and mental capacity training.
- We noted the mandatory training staff had completed was not fully in line with the current best practice guidelines for ongoing social care staff training. For example, topics recommended for social care staff were not included in what the provider considered was mandatory, such as equality and diversity, dignity, person centred care and nutrition and hydration. We saw that this training was available to staff but not all staff had completed it. For example, only three staff out of 16 employed by the provider had completed training in person centred care. Only six out of the 16 staff had completed training in dignity and respect.
- Despite some people being at high risk of falls only one staff member had received training in falls management.
- Staff were not trained in oral care in line with current best practice guidance. We noted that one person had recently needed treatment for an oral infection and required support from staff to meet their specific needs.

Failing to ensure staff received appropriate training and professional development, as was necessary to enable them to carry out the duties they were employed to perform was a continued breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff told us they received an induction when they started in their role. We saw evidence that some staff had received supervision.

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.

● During this inspection we found people were being deprived of their liberty without appropriate assessments of their mental capacity and the required authorisations from the funding authorities or the court of protection. This is described in more detail in the Safe section of this report

● Staff were able to tell us how they ensured they sought consent and offered choices to people on a day to day basis and we observed staff asking people for permission and involving them in day to day choices. However, we noted consent to care and treatment and best interest decisions had not always been obtained in line with legislation and guidance, such as the MCA.

● The service does not always assess people's mental capacity to make particular decisions, or did not always do so in a way that met legal requirements. For example, staff had undertaken a mental capacity assessment regarding a decision to sell a person's own home to fund their care at Fourways Residential Home. Where that was the case, required best interest decisions had not been made in line with legislation as staff did not have the legal power to make this decision. This person was found to not have capacity to make this decision. However, we found no recorded evidence that mental capacity assessments had been completed on whether this person could consent to their care and treatment or to reside in the home itself.

Failing to obtain lawful consent to care and treatment from the relevant person was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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

● Assessments were undertaken prior to a person moving to the home. However, we found these were not completed in full and important information about people was not always captured to ensure staff understood what was important to people prior to receiving care. For example, one person's care records had been left blank in the section requiring information on the person's routines, what makes them feel better when they are upset or what was important to them. This person had moved into the home in 2017.

● One person who had recently had an oral infection did not have an oral health assessment or care plan in place, in line with best practice and national guidance. This meant staff did not have the appropriate guidance available on how the person should be supported with their oral hygiene and in the way they preferred.

Failing to ensure people's needs are fully assessed in line with best practice, national guidance and legislation was a breach of Regulation 9 (Person-centred care) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Although the quality of assessments and people's care plans needed improvement, most people and their relatives felt the standard of care they received was good.

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

● The decoration of the home and some of the fabric of the building was in poor condition. We found flooring in poor condition, with holes, worn spots and significant staining.

● We found that the shower room sink's hot tap had very low water pressure and there was no hot water from this tap.
● During the inspection we found areas of the carpet in the conservatory were wet. We informed the nominated individual who advised that they believed this to be due to the recent heavy rain and there must be a leak. However, at the end of the inspection we found there had been no steps taken to address this issue.
● At the last inspection we found that the provide had not ensured the environment met the needs of people who lived there with dementia. Since the last inspection the provider had added signage to doors to support people with a cognitive impairment to locate their bedrooms and communal facilities such as the toilets. However, we found that further improvement was needed to support people with cognitive impairments such as dementia. For example, there were no dementia friendly areas in place to provide stimulation to those who were living with the condition. Toilets seats were not in contrasting colours to aid people to maintain continence.

Failing to ensure that the premises and equipment were suitable for their purpose and were properly maintained was a breach of Regulation 15 (Premises and equipment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The nominated individual confirmed the would be replacing the flooring in the home following the inspection.
● People's bedrooms were personalised in a way they preferred with photos of loved ones and their personal belongings.
● Some people had recently had their carpet replaced in their bedroom.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Staff failed to ensure a person received appropriate healthcare support following a fall. One person had a fall at night and was displaying signs of pain. Records indicate that staff failed to call for medical assistance and just supported the person to bed and monitored them sleeping. An ambulance was called the following day and the person was admitted to hospital where they were found to have a fracture. We have dealt with this in the safe domain.
● Referrals to speech and language therapists, dietitians and tissue viability nurses were made when needed.
● Staff worked alongside GP's and other associated healthcare professionals to meet people's needs.
● A healthcare professional told us, "The home seem to work well with the GPs and I have always been kept informed of the health needs about patients [people]."

Supporting people to eat and drink enough to maintain a balanced diet
● People had access to a varied and balanced diet. People and their relatives spoke positively about the food they received. One person told us, "Lunch was lovely. He's a very good chef and he's so considerate." Another person said, "The food is very good. It's not bad grub here at all, I'd give it 9.5 out of 10."
● We observed the chef working with people in a person-centred way by offering them food that they wanted. During our lunchtime observations we saw people had a variety of different foods that they chose.
● We saw people were supported to stay hydrated with designated hydration and nutrition stations containing water, juices and fruit. One staff member told us, "We offer biscuits or fruit, to encourage people to eat fruit." One person commented "…we have juice whenever we want."
● We observed people over the lunchtime period and saw staff offering people support where required. People appeared to be contented and happy with their lunchtime meal.

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.

Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care

- We found that people's privacy and dignity was not always maintained. For example, during the inspection we found a list of when people had a bath on a notice board in the hallway that all people and visitors could see. This detailed the person's name and which days they would be having a bath. We explained to the acting manager that this did not reflect that people's privacy, dignity and confidentiality was maintained. The list was removed this from the notice board.
- Health and social care professionals didn't always feel people were treated with dignity. One professional told us when asked if people are treated with dignity and respect, "Dignity, not always, as some residents are treated in the same way as [a person with dementia] would be…"

We recommend the registered provider seeks guidance from a reputable source and implement best practice on ensuring that the privacy, dignity and respect of people are always maintained.

- We received mixed feedback from people on how they were supported to make decisions about their care. Some people told us that some decisions were made for them, but they had not been asked. For example, one person said, "We have our set days for a bath…I could have a different day if I asked."
- From our observations during the inspection we saw staff asking people how they would like things done and what they preferred. For example, we observed one staff member say to a person, "Where would you like to sit [name]?"
- We saw the chef offering people choices for their lunchtime meal. One person said that if they changed their mind about the choice they had made, "We can change our mind and [the chef] will change it."
- Resident's meetings were held which provided people the opportunity to feedback about the service and any concerns they may have. We looked at the most recent residents meeting minutes from January 2020 and found that staff were discussing a number of topics with people, giving them an opportunity to feedback.

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

- People told us they were well treated by staff. One person said, "The staff are always helpful and kind." A relative told us about the relationship between care staff and their loved one, "They [staff] are very kind to her."
- A relative told us, "It was [loved ones] birthday last week and [the chef] made a lovely cake for her, everyone had some."

● We observed positive interaction between people and staff, which was warm and positive. This indicated a presence of positive relationships between staff and the people they cared for.

● Staff explained how they got to know people and worked to build up a good rapport. Staff talked about people in a caring and respectful way.

● During the inspection we observed staff respecting people's preferences, and providing care in a way that supported people in a non-discriminatory way.

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 Requires Improvement. At this inspection this key question has remained the same. 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; End of life care and support; 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

At the last inspection we made a recommendation that the provider looks at ways to ensure people are offered activities that are personalised, reflective and responsive to their changing needs. In addition, to seek guidance sought from reputable sources to support this process.

At this inspection we found the provider had not made the necessary improvements.

● It was not always clearly documented what activities people had participated in which met their social preferences to ensure they avoided isolation. People told us that they did not feel they were supported to do things they enjoy. One person said, "We don't have activities every day and we don't have an activity person. Sometimes the carers [staff] will do something but they're busy." Another person said, "It would be nice to go out now and again."
● People's care records did not fully identify their interests and preferences in relation to socialisation and activities. It was not always clear how people were supported to engage in activities of their choice or how staff knew about people's individual preferences or past interests and hobbies. One person told us when we asked if they do things they enjoy, "I am Mrs Nobody really. I used to be [profession]."
● We reviewed the records of activities people had been offered and taken part in and found that these were sometimes based around people's personal care needs and relatives visiting the person. For example, one person's records did not evidence that staff had explored what was important to them or what their preferences were in relation to activities. Their activities records over a 27 day period stated that they had had their hair brushed, had a shave and had two visitors. We looked at an additional written record which stated that from 4 January 2020 to 7 February 2020 the person had listened to music on five occasions and watched a DVD on one occasion.
● The service did not have any designated activities coordinators. The nominated individual told us that they expected all staff to support with this. However, no staff had received any training on the provision of activities to older people.
●During the inspection we observed care staff engaging with people in some activities such as throwing a ball and listening to music. However, people were not always enjoying this. One person was observed saying, "I don't like the music particularly but perhaps I'll just curl up in bed then."
● People did not always receive personalised care which met their needs and choices. People were not offered a choice of how often, when, or how they had a bath. A rota showed that people had an allocated

'bath day'. People told us that they had a set time. One person said, "I have had these days allocated to me since 2012 and I am happy with it. I suppose that if I wanted a bath on other days, I could ask the staff, but I have never asked them."

● Records indicated that bathing was confined to these times. However, we could not always be sure that people received baths. A staff member told us that the night staff will often get people up in the morning and wash them. They said, "The night staff will give washes to people who are already up and also support them to get dressed." They went on to say, "People who have washes don't have baths and the night staff assist at least five to six residents [people] with washes daily." We noted that when we arrived for inspection before 9am that 11 people were already dressed and sitting in the living room.

● One person who had come to the home in December 2019 did not have their dentures for a period of time as they had been lost in hospital and in the home. Their care plan stated, "I worry about losing my teeth." As a result of not having their dentures the person was eating soft or pureed food as they could not chew a more solid consistency of food. We found that the management had not referred them to a specialist service to address this concern until the middle of January 2020.

● Health care professionals did not always feel that people's individual needs were met. One professional told us, "No not always as residents need to be treated as individuals and not as an illness."

● At the time of the inspection we were informed that no one was receiving end of life care. Care records showed that there were specific sections of the care plan that should be completed for end of life care wishes and preferences. However, records evidenced that this had not always been explored with the person. There was not always specific detail on how staff should support people with end of life care or in the event of a sudden death. This meant staff did not always have the information needed to meet people's needs at this time. For example, one person's end of life care plan had not been completed. Another person's care plan stated they had a do not attempt resuscitation protocol in place but did not detail any information on this person's preferences when they required end of life care. There was no record that the person had been asked for their wishes.

Failing to ensure that people's care and treatment was person-centred, appropriate, met their health and social care needs and reflected their preferences was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some people commented that they did enjoy particular activities that took place. One person said, "We play snakes and ladders and dominoes." Another person said, "We go out in the Summer in the minibus."

● Relatives told us they were able to visit their loved ones freely and felt welcome in the home. One relative said, "We're welcome anytime and we get a cup of tea."

● People told us about the resident cat and we observed people enjoying its company. One person said in a joyful manner, "There's a cat here you know, it sits on my lap every day, I call it Cat."

● Staff received training in end of life care, to provide them with knowledge and general guidance on how to ensure this was as comfortable as possible for people and their relatives.

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.

● Staff were aware of people's communication needs and, for example, whether people needed spectacles and hearing aids to effectively communicate their needs.

● The acting manager told us they could provide information in alternative formats should it be required.

Improving care quality in response to complaints or concerns

● Although we received concerns prior to the inspection that staff did not feel listened to, staff we spoke to during this inspection said they felt supported by the management to undertake their role effectively and that the management team would act on any concerns they raised.

● People's complaints were responded to appropriately. The provider kept a record of concerns, complaints and compliments.

● People told us they were able to speak with staff or managers and raise any concerns. One person told us, "If I had an issue I would tell [manager] or someone else."

● We were informed there had been one complaint since the last inspection. Records showed this was responded to appropriately.

Inadequate

Is the service well-led?

Our findings

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

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At the last inspection we found that the registered provider had not ensured that processes and systems were effective or established to ensure compliance. Audits were not completed, and risks were not mitigated. This was a breach of Regulation 17 (Good governance) 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 17.

● At the last inspection the provider was asked to submit an action plan following the concerns identified. They informed us they would ensure they did the following by the end of October 2019:
- All support plans to be reviewed to ensure that they reflect the changing needs of people being supported.
- A refurbishment schedule to be introduced to ensure that the building reflects the changing needs of the people being supported.
- The homes dependency tool to be utilised to ensure that that there are enough qualified and experienced staff to meet the needs of the people being supported.
- The home's furnishing and décor to be reviewed in line with current guidance on supporting people with cognitive impairment, including dementia etc.
- To carry out a review of the roles and responsibilities of the registered manager and deputy to ensure that the service is managed appropriately.
- A review of staffing needs to include activities coordinator
● We found that the registered provider had not made the improvements they said they would in their action plan.
● During this inspection we found breaches of 10 regulations in the fundamental standards of regulations 8 – 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The systems and processes the provider had in place had not enabled the provider to ensure they reached and maintained compliance with the fundamental standards. The audit and monitoring systems in place had not identified the regulation breaches we found at this inspection.
● Effective systems to assess, monitor and improve the quality and safety of the services provided were not in place.
● Effective systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of

people and others were not in place. Records did not always clearly evidence that risks to people were being mitigated.

● People's records and care plans were not always accurate, complete and contemporaneous. The inconsistent documentation meant that information was not always reflective of people's needs, and this had not been identified by the registered person. We found that accurate records were not always maintained or did not accurately reflect the support people were being offered. This potentially placed people at risk and could compromise the quality of the care being delivered.

● We found people's daily records were inaccurate. For example, one person had gone to hospital, however, staff had recorded entries that they were still monitoring the person despite them no longer being in the home. This had not been picked up by the provider and this questioned the validity of people's daily notes and the effectiveness of the provider's audit system.

● Investigations into incidents were not comprehensively recorded. The provider did not have a robust system in place to record and learn from incidents. There was no system in place to identify any near misses in order to improve safety.

● We reviewed feedback from surveys people had completed and also feedback provided at residents meetings. However, we found where there was a concern or issue raised there was not always actions on what the provider would do to address the concerns or make the necessary improvements.

● A health and social care professional told us, "Significant concerns remain around management and leadership of the home, quality assurance, reporting of concerns and staff culture/training."

● We looked at the provider's dependency tool which was used to calculate how many staff were required to meet people's care needs and how many minutes they needed from staff to provide care. People were categorised into high, medium and low need. However, we found that a person who was categorised at medium need and only needing one member of care staff to support them was allocated the same amount of time as a person who required two staff to deliver personal care. This meant that both received the same amount of care time from staff despite the one person requiring double the amount of time (two staff). This meant that accurate and effective systems were not in place to ensure sufficient numbers of staff were deployed to support people.

The registered provider failed to establish effective systems and processes to ensure compliance with the fundamental standards of care. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Services registered with Care Quality Commission (CQC) are required to notify us of significant events, or other incidents that happen in the service, without delay. During the inspection we found that the registered person had not always notified CQC of reportable events such as a death of a person. This meant we could not check that appropriate action had been taken to ensure people were safe. We raised this with the nominated individual and they submitted missing notifications on the day we raised it.

The registered person failed to notify the CQC of notifiable events without delay. This was a breach of Regulation 16 (Notification of death of a service user) of the Care Quality Commission (Registration) Regulations 2009.

● It is a condition of the provider's registration to have a manager in post who is registered with the CQC. However, the provider had failed to meet this condition. The previous manager had deregistered in May 2019 and a new manager of the home had started in May 2019. We contacted the provider in October 2019 as we had still not received a registered manager application. Following this we received an application for a registered manager however this application was rejected on the 15 October 2019 due to incorrect information. We received no further applications and there was still no registered manager in post at the

time of this inspection.

Failing to ensure there is a manager registered with the CQC is an offence under section 33 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the nominated individual sent information on what action they planned to take following the concerns identified during this inspection. However, due to finding a number of previous breaches and identifying that provider had failed to act on previous concerns or ensure enough improvement had been made to reach or maintain compliance. We could not be assured that appropriate action would be taken. We could not be assured that any action taken would be sustained.

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
● It was not always clear if the provider had acted on their duty of candour. A person suffered a serious injury. The provider had recorded the incident itself but there was no evidence that the provider had conducted a full investigation into the incident. During the inspection we identified some failings regarding this incident. The nominated individual acknowledged these failings during the inspection, however, there was no evidence that the provider had been open and honest regarding the failings identified with the person or a relevant person.

The registered person had failed to always act in an open and transparent way with relevant persons in relation to care and treatment provided to people in carrying on a regulated activity. This was a breach of Regulation 20 (Duty of candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the nominated individual sent us details of actions they would be taking in relation to this incident to ensure they met this fundamental standard.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● There was a mixed approach to the culture of the home. People and relatives, we spoke with were unclear as to who or how the home was being managed.
● Peoples care needs were not always being met as detailed in this report and this had an impact on their safety.
● Staff demonstrated pride and enjoyment in their roles and valued making a homely atmosphere for people and visitors.
● There was an 'open door' management approach. The management team were easily available to staff, relatives and people living in the home.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider had undertaken quality assurance surveys with people.
● The provider had recently introduced a residents meeting which gave people the opportunity to feedback on ways the service can be improved. One person told us, "We've started to have residents' meetings."

Working in partnership with others
● There was evidence in people's care records that the service worked with local health providers.
● A health and social care professional told us, "The home have always liaised with other agencies involving

my patients [people in the home] when needed."

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 16 Registration Regulations 2009 Notification of death of a person who uses services How the regulation was not being met The registered person failed to notify the Care Quality Commission of deaths of service users without delay. 16(1)(a)

The enforcement action we took:

In light of the current situation CQC has taken the necessary steps to review the breaches identified in respect of the above regulated activities. We have also taken account of the impact of any enforcement activity would have on the Provider and the additional pressures that they are currently facing in light of the COVID-19 pandemic. At this time, we have therefore decided against undertaking enforcement activity and to instead ask the provider to focus on driving improvement.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care How the regulation was not being met The registered person failed to ensure that care and treatment of service users was designed with a view to achieving their preferences or ensuring their needs were met. Service users were not being enabled or supported to understand their care and treatment choices. Regulation 9(1)(a)(b)(c)(3)(a)(b)(c)

The enforcement action we took:

In light of the current situation CQC has taken the necessary steps to review the breaches identified in respect of the above regulated activities. We have also taken account of the impact of any enforcement activity would have on the Provider and the additional pressures that they are currently facing in light of the COVID-19 pandemic. At this time, we have therefore decided against undertaking enforcement activity and to instead ask the provider to focus on driving improvement.

Regulated activity	Regulation

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent How the regulation was not being met The registered person had failed to ensure that care and treatment of service users was only provided with the consent of the relevant person. Regulation 11(1)(3)

The enforcement action we took:

In light of the current situation CQC has taken the necessary steps to review the breaches identified in respect of the above regulated activities. We have also taken account of the impact of any enforcement activity would have on the Provider and the additional pressures that they are currently facing in light of the COVID-19 pandemic. At this time, we have therefore decided against undertaking enforcement activity and to instead ask the provider to focus on driving improvement.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met The registered person failed to ensure safe care and treatment. The registered person had not always ensured the proper and safe management of medicines. Assessments of the risks to the health and safety of service users of receiving care or treatment were not always carried out. The registered persons had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment.Not all staff providing care and treatment had the qualifications, competence, skills and experience to do so safely. Regulation 12(1)(2)(a)(b)(c)(g)

The enforcement action we took:

In light of the current situation CQC has taken the necessary steps to review the breaches identified in respect of the above regulated activities. We have also taken account of the impact of any enforcement activity would have on the Provider and the additional pressures that they are currently facing in light of the COVID-19 pandemic. At this time, we have therefore decided against undertaking enforcement activity and to instead ask the provider to focus on driving improvement.

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

How the regulation was not being met: The registered person was depriving service users of their liberty without lawful authority to do so.

Regulation 13(1)(5)

The enforcement action we took:

In light of the current situation CQC has taken the necessary steps to review the breaches identified in respect of the above regulated activities. We have also taken account of the impact of any enforcement activity would have on the Provider and the additional pressures that they are currently facing in light of the COVID-19 pandemic. At this time, we have therefore decided against undertaking enforcement activity and to instead ask the provider to focus on driving improvement.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment How the regulation was not being met The registered person had failed to ensure that the premises used by the service were properly maintained. The registered person had failed to ensure that the premises used by the service were suitable for the purpose for which they are being used. Regulation 15(1)(c)(e)

The enforcement action we took:

In light of the current situation CQC has taken the necessary steps to review the breaches identified in respect of the above regulated activities. We have also taken account of the impact of any enforcement activity would have on the Provider and the additional pressures that they are currently facing in light of the COVID-19 pandemic. At this time, we have therefore decided against undertaking enforcement activity and to instead ask the provider to focus on driving improvement.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance How the regulation was not being met The registered person had not established and operated effective systems and processes to ensure compliance with the fundamental standards (regulations 8-20A). There were no effective systems in place to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. The registered person failed to ensure that accurate, complete and contemporaneous records were

being maintained in respect of each service user. The registered person failed to evaluate and improve their practice in respect of the processing of the information obtained through their governance process.

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

The enforcement action we took:

In light of the current situation CQC has taken the necessary steps to review the breaches identified in respect of the above regulated activities. We have also taken account of the impact of any enforcement activity would have on the Provider and the additional pressures that they are currently facing in light of the COVID-19 pandemic. At this time, we have therefore decided against undertaking enforcement activity and to instead ask the provider to focus on driving improvement.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour How the regulation was not being met The registered person failed to always act in an open and transparent way with relevant persons in relation to care and treatment provided to people in carrying on a regulated activity. 20(1)(2)(3)(a)(b)(c)(d)(e)

The enforcement action we took:

In light of the current situation CQC has taken the necessary steps to review the breaches identified in respect of the above regulated activities. We have also taken account of the impact of any enforcement activity would have on the Provider and the additional pressures that they are currently facing in light of the COVID-19 pandemic. At this time, we have therefore decided against undertaking enforcement activity and to instead ask the provider to focus on driving improvement.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing How the regulation was not being met The registered person had failed to ensure that persons employed in the provision of a regulated activity received such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform. The registered person had failed to ensure that sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed in order to meet the requirements of fundamental standards.

Regulation 18(1)(2)(a)

The enforcement action we took:

In light of the current situation CQC has taken the necessary steps to review the breaches identified in respect of the above regulated activities. We have also taken account of the impact of any enforcement activity would have on the Provider and the additional pressures that they are currently facing in light of the COVID-19 pandemic. At this time, we have therefore decided against undertaking enforcement activity and to instead ask the provider to focus on driving improvement.