CareEast 2 Ltd

Mead Lodge Residential Care

Inspection report

Mead Lodge
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Tel: 01603279261

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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?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Mead Lodge is a care home registered to provide accommodation and personal care to a maximum of 24 older people. At the time of the inspection there were 20 people living in the service.

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

We carried out this inspection in response to concerns about the safety and welfare of people using the service.

People didn't always receive support from staff at the time they required it. Staff did not respond to people's requests for support in a timely way and this compromised people's safety, welfare and dignity.

People's medicines were not always managed and administered safely. This led to some people not receiving medicines prescribed for them.

Risks to people had not always been identified and planned for. This meant staff did not always have access to information which could guide them on how to reduce risks.

The service did not have an adequate system in place to analyse accidents and incidents for trends. This meant they had not identified trends which they could have acted on to protect people from harm.

The support people needed to reach and maintain a healthy weight was not always documented.

The quality assurance system in place had not identified the shortfalls we identified during our inspection. The company directors did not have a quality assurance system in place to assess the quality and safety of the service at provider level. This meant they did not have adequate oversight of the service.

We were not assured that staff always received appropriate training for the role. Training records demonstrated staff had not always received training in subjects relevant to their role.

Improvements were required to ensure that people's views about their care were reflected in care planning. Care plans were not always personalised to include information about people's preferences and life history.

Improvements were required to ensure that people's capacity to make decisions was consistently assessed under the Mental Capacity Act 2005 and that formal best interests' processes were followed where appropriate.

Despite the concerns we identified, people told us they felt safe. Recruitment procedures were safe.

People told us care staff were kind and caring towards them.

You can see what action we have asked the provider to take at the end of this full report.
Rating at last inspection: The last rating for this service was good (published 1 February 2019).

Why we inspected
This inspection was carried out in response to concerns about people's health, safety and welfare.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our Safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not caring.

Details are in our caring findings below.

Inadequate

Is the service responsive?

The service was not responsive.

Details are in our responsive findings below.

Inadequate

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate

Mead Lodge Residential Care

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by one inspector.

Service and service type
Mead Lodge is a care home for older people, the majority of whom were living with dementia. People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided in line with the Health and Social Care Act 2008 and associated Regulations.

Notice of inspection

The inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. This included notifications the service had made, and the details of concerns raised with us about the service. We used all of this information to plan our inspection.

During the inspection
We spoke with six people who used the service and one relative about their experience of the care provided. We spoke with eight members of staff including the registered manager, deputy manager, nominated individual, a director of the company and care staff. Service's are required to register a nominated individual. A nominated individual is a senior person with authority to speak on behalf of the organisation. They carry responsibility for supervising the management of the carrying on of the regulated activity

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

Inadequate

Is the service safe?

Our findings

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

We carried out this inspection in response to concerns raised with us by external healthcare agencies and because of concerns about the number of serious injuries the service was notifying us of.

At the last inspection this key question was rated as good. At this inspection we found that the service had deteriorated and there were significant shortfalls which placed people at the risk of avoidable harm. The service is now rated inadequate in this key question.

This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment
• A review of 12 serious injury notifications made by the service demonstrated that 10 of these occurred on the night shift. As a result, we attended the service whilst the night staff were still on duty.
• On arrival we observed that two people had been waiting for 25 minutes and 20 minutes respectively for staff to answer their call bell, which they had pressed to request staff assistance.
• We carried out a review of call bell records between 16 July 2019 and 18 July 2019. These demonstrated that on occasions, people were waiting an extended period of time for staff support. This ranged from 10 minutes to over 60 minutes. For example, on 20 occasions staff took between 10-20 minutes to respond, on 15 occasions they took 20-30 minutes to respond, on four occasions they took 30-40 minutes to respond and on four occasions they did not respond for over 60 minutes.
• We observed one person who was brought to the dining area for breakfast in their wheelchair. They were provided with their breakfast but then staff did not return for an hour, by which point the person was becoming restless and asked us to find a staff member because they had no way to call for staff assistance. We asked the person if they often had problems getting support from staff when they needed it. They said, "Quite a lot of the time, yes." This person also told us they had episodes of urinary incontinence because staff did not attend quickly enough to support them to use their continence aid. They said, "You just can't get an answer when you need to go, it makes me feel so embarrassed." A review of the call bell records for this person identified that between 16 and 18 July 2019 they had waited between 10-20 minutes for staff to respond to their bell on four occasions, between 20-30 minutes on six occasions and over 30 minutes on two occasions.
• Other people told us there were not enough staff to meet their needs in a timely way. One said, "You just can't get anyone. You buzz, and they don't come. You end up wetting yourself because they are too slow. Often, they come in, turn off the buzzer and say they will be back in a few minutes but that turns into hours." Another person said, "You can be sitting there for ages, sometimes half an hour or more before they turn up. I know they are busy and it's not their fault but it's hard for us."
• Sensor mats were in place for many people at risk of falls to alert staff that people were mobilising. However, records of response times to these activating between 16 and 18 July 2019 showed that staff did not always respond in a timely way. Between these dates records showed that staff took between 10-20 minutes to respond on 16 occasions, between 20-30 minutes on 13 occasions, between 30-40 minutes on

three occasions, between 30-40 minutes on three occasions and over 60 minutes on five occasions. This meant that we were not assured staff were responding quickly enough to protect people from the risk of avoidable harm as a result of falls.
• The registered manager and company directors had not carried out a dependency assessment to ascertain how many staff were required to meet people's needs. The company directors told us they felt the staffing level was appropriate for the numbers of people but had not taken into account their needs and dependency level.

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

• The service practiced safe recruitment procedures. This included carrying out checks to ensure prospective staff were safe to work with vulnerable people.

Assessing risk, safety monitoring and management
• There were shortfalls in the identification of and planning for risks to people. Whilst the registered manager told us the care plans were still being developed, they did not contain basic information about reducing some risks to people.
• There was limited care planning in place to indicate to staff how the risk of people choking should be reduced. For one person, specific information on reducing this risk had been provided by the Speech and Language Therapy Team (SALT) but this had not been reflected in their care planning, so it was unclear how staff would know about this guidance and take all possible action to reduce the risk of this person choking.
• Where people had been assessed as at risk of pressure ulcers, clear care planning was not always in place to guide staff on how these risks were reduced. For example, the care plans for some people did not make clear whether they required repositioning by staff.
• One person had a specific repositioning routine in place because their skin had started to show signs of early pressure damage in one area. We reviewed the repositioning records for this person and these demonstrated staff were not always following this routine and the person was on occasions not being repositioned for extended periods of time. This person was reliant on staff for repositioning. During our inspection we also observed there were no bumpers on the person's bed rails. This meant they were at risk of injury from entrapment.
• Where people had specific conditions or diseases, such as cancer, this was not always evident from their care records. This meant it was unclear whether they required any support with these conditions.
• The service was currently in the process of recruiting and were using a high number of agency staff to cover their shifts. These staff would be more reliant on accurate care planning and assessments to understand the care they should deliver to people. The absence of this information put people at risk of receiving unsafe or inappropriate care.
• The service had an external company check their water for the presence of Legionella bacteria, and this was not present. However, the service had not carried out flushing of the water system or checks on the temperature of hot and cold water taps since April 2019. This meant all possible measures were not in place to reduce the risk of the presence of Legionella in the water system.
• The door to the sluice room was open during the morning of our visit, when three people living with dementia were actively walking around the service continuously. This presented a risk as this room contained chemicals which could be harmful to people if ingested.

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

• Processes were in place to monitor the safety of the building and the equipment within it. This included

regular safety checks on electrical appliances, lifting equipment, mobility aids and window restrictors.

Using medicines safely
• There were shortfalls with the way medicines were managed and administered in the service. This meant people had not always received their medicines as prescribed.
• One person was prescribed Warfarin, which is a high risk blood thinning medicine. This person had been prescribed differing doses of this medicine on different days of the week. The person's Warfarin records had been poorly completed on some occasions, which did not reflect best practice. In addition, records showed that on 14 July 2019 they had been administered an overdose of Warfarin which was not in line with their prescription. The service had not identified this independently and therefore had not sought the advice of a doctor until we highlighted the concern.
• For other medicines, record keeping was so poor it was unclear whether they had been administered as prescribed. This included one person's antibiotic, which had been prescribed to treat an infection. If they had not been administered these as prescribed it could have compromised the effectiveness of the medicine in treating their infection.
• Some people using the service were prescribed 'as and when' (PRN) medicines, such as those with a sedative effect, to be administered when their behaviour presented a risk to themselves or others. These medicines should only be administered as a last resort. However, records demonstrated the service had administered one person's medicine on 17 consecutive days. This medicine had not been prescribed for daily use. We asked the registered manager why the person was being administered the medicine and we were told it was because they became agitated. However, we were told they did not present behaviours that could cause harm to others using the service. This meant we were not assured the service was using this medicine for the purpose which it was prescribed.
• The registered manager told us about another person who had been discharged from hospital having had all their medicines stopped, including a PRN medicine which had been prescribed for agitation. We were told that the service was looking to have this medicine prescribed again, because of the person's "Wandering." 'Wandering' is considered an unhelpful phrase used to describe a person living with dementia who walks about, as it suggests the person is walking without purpose, when usually there is an underlying purpose. We were told the person was not at risk of falling when walking with purpose. Therefore, we were not assured the service planned on using this medicine as a last resort and for the purpose which it was intended.

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

Preventing and controlling infection
• The service was not clean. There were brown stains in multiple areas in the hallway which continued into the lounge. There was a crusted brown stain on the landing upstairs and a lump of a brown substance by the threshold of one of the internal doors. The registered manager told us it was faeces and they were aware of one person who was struggling to maintain their continence needs independently. They told us they expected staff to 'spot clean' the carpet when this occurred and for the domestic staff to clean the carpet when they arrived for their shift. They told us the staff had been unable to clean the carpet upstairs as they couldn't lift the carpet cleaner up there. This meant the faeces had been present on the carpet for an extended period of time.
• We observed domestic staff cleaning the carpet after we raised this with the registered manager. However, brown marks remained on the lounge carpet along with stains resulting from a liquid substance.
• There were half eaten biscuits and food on the floor in the lounge along with dirty tissues. Some of the furniture was not clean and there were crumbs and other substances on the chairs.
• One person's bedding had a stain on it and there were splits in the covering on crash mats in use which

meant they could not be effectively cleaned. In places there were also splits in linoleum flooring which meant these floors could not be sanitised effectively.
• All of the above meant we were not assured that the service was taking appropriate action to limit the risk of the spread of infection.

This constituted 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
• We carried out this inspection in response to concerns raised with us by external healthcare organisations and because of concerns we had about the high number of serious injuries being reported by the service. This included serious injuries occurring as a result of falls.
• The service had failed to analyse falls and serious injury data to identify the trends. As a result, they had not taken any action to investigate why there were a higher number of serious injuries occurring at night.
• In addition, they had not carried out a review of call bell and sensor mat response times to ascertain whether staff responded in a timely way. The registered manager told us the Falls Prevention Team were satisfied they had all appropriate measures in place to reduce falls. However, these measures were ineffective because records demonstrated staff did not respond promptly enough when people triggered their sensor mats. The failure to identify this meant that people were put at risk of avoidable harm.

This constituted a breach of Regulation 12: 'Safe Care and Treatment' of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
• Despite the concerns we identified, people told us they felt safe living in the service. One said, "I do feel safe here, safer than I did at home before."
• Staff had a good understanding of safeguarding, the different types of abuse and their responsibilities in protecting people from harm.

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 we found that improvements were now required. The service is now rated requires improvement in this key question.

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

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

We checked whether the service was working within the principles of the Mental Capacity Act (MCA).

• The service had not consistently assessed people's capacity to make specific decisions in accordance with the MCA where required. Generalised assessments of people's ability had been carried out, but this could mislead staff into thinking people couldn't make any decisions independently.
• Care planning for some people stated that staff should make best interests' decisions on their behalf. However, care planning did not refer staff to following formal best interests processes in line with the MCA. Care planning contained limited information about people's preferences, so it was unclear how staff could make decisions in line with people's past preferences.
• The management team had made DoLS referrals where these were required. However, the family of one person had written to the service after receiving a copy of their relatives authorised application stating that much of the information within the application was inaccurate. This meant the local council could have authorised the application on the basis of incorrect and inaccurate information about the person.

This constituted a breach of Regulation 11: Consent to Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Despite our findings, people told us that staff gave them choices. One said, "They'll let me make the

decisions." We observed that the majority of the time, staff gave people opportunities to make decisions independently. However, this was not always the case with people who had more advanced dementia.

Supporting people to eat and drink enough to maintain a balanced diet
• The support people required with eating and drinking was not always clearly documented in their care records. Where people were assessed as at risk of malnutrition or dehydration, information was not always available to guide staff on how to protect people from this risk.
• Daily records did not always demonstrate that people had been offered a sufficient amount of fluid. For example, on 16 July 2019 staff had recorded that one person had drank 600ml of fluid, there were no other records to support that more than this was offered. This person was unable to request a drink from staff or drink independently. Care plans did not make clear what people's fluid target was for each day.

This constituted a breach of Regulation 14: 'Meeting Nutritional and Hydration Needs' of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People told us the food they were provided with was good quality. One said, "The food is good, the choice is good. Can't complain."
• Whilst the mealtime lacked atmosphere, people did receive the support they required to eat. People were provided with equipment such as plate guards to enable them to eat independently.
• Staff were on hand to offer people ad hoc support where required and identified where people were not eating. One person was refusing their meal, but different staff kept speaking with them and attempting to encourage them. They were offered different meal options and with encouragement and adaption to what was on their plate, we saw they began to eat their meal.
• Improvements were required to how the service supported people living with advanced dementia to choose their meals. It was unclear how they could make a meaningful choice and there was limited information available about their preferences for staff to support them effectively. The service should consider best practice guidance around supporting people living with dementia at meal times.

Staff support: induction, training, skills and experience
• Staff were provided with training in a number of subjects relevant to the role. However, the training matrix provided by the service demonstrated that not all staff were up to date with training in subjects the service deemed mandatory. For example, the training matrix showed three staff were overdue for their fire training. Six staff had not received first aid training. Two had no moving and handling training, 13 staff had not received training in managing behaviour that challenged, six staff had not received training in dementia awareness or food hygiene and nine had not received training in end of life care.
• Despite this, staff told us they felt their training was good and they were supported by the registered manager.

Staff working with other agencies to provide consistent, effective, timely care and supporting people to live healthier lives, access healthcare services and support
• Referrals to other healthcare professionals had been made where this would have been appropriate. However, the guidance provided was not always transferred into care planning to ensure staff could implement this consistently.
• Where measures, such as those for reducing the risk of falls, had been implemented on the advice of professionals, the service did not monitor the effectiveness of these measures. This meant they had not identified that staff practice meant these measures were not always effective in reducing risks.
• The service had not always followed the prescriber's instructions on some 'as and when' (PRN) medicines. They had not consulted healthcare professionals about their continued and frequent use of these medicines beyond what they were prescribed for.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Comprehensive assessments were carried out of people's needs before the service started supporting them.
• People's care records were not always written in a way that reflected best practice guidance, such as that produced by the National Institute for Health and Care Excellence (NICE).

Adapting service, design, decoration to meet people's needs
• The service was not decorated in a way which supported people living with dementia to orientate themselves around the building. Corridors were not decorated individually so people could recognise different areas of the service.
• People's bedroom doors were not decorated in a way which made it easier for people to identify which room was theirs.
• Signage could be improved to make key areas such as toilets, lounges and dining rooms easier to locate.

Inadequate

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 we identified concerns about the quality of the care people received. The rating in this key question is now Inadequate in this key question.

This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity
• Whilst we observed that staff were kind to people and were intuitively caring in nature, the company directors and registered manager did not promote a culture of caring. This was because widespread shortfalls in the quality of the care people received meant that people were not always consistently well treated or cared for. These had not been identified and acted upon.
• People felt that staff did not respond to them when they were in need, which meant they may not feel valued. One person said, "I feel like they just ignore me most of the time." Another said, "When you see them they are nice enough, but they are scarcely available."
• The company directors and registered manager had failed to identify and address shortfalls in staffing which meant that people sometimes waited unacceptable lengths of time for their needs to be met. Staff told us that care was 'task focussed' and this confirmed our observations. They told us they had no time to spend with people unless it was attached to a task, such as delivering personal care.
• Staff continuity was poor, with a high level of agency use which meant that people did not always receive care from people who knew them. A lack of information available about people's preferences meant that we could not be assured new or agency staff could deliver people person centred care. People told us they did not feel all the staff knew them. One said, "Different faces all the time. You get used to one and build a rapport and then they're gone. Some know me but then some you're having to tell them all the time. I feel sorry for the one's who can't say what they want and don't want, what do they get?"
• The inaction of the company directors and registered manager meant we were not assured that they were caring. One person made a negative comment about one of the company directors and told us, "[Company director] seems impatient, never said a word to me but [they] are really rude to the staff which I don't like." Others we spoke with during the course of the inspection also made negative comments about the behaviour of this company director.

This constituted a breach of Regulation 10 'Dignity and Respect' of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to express their views and be involved in making decisions about their care
• People told us they had not been involved in the planning of their care and did not feel involved in decision making. One said, "I know we talked about everything when I first came but not since then, I have been here

two years now." Another commented, "No one has mentioned anything, I guess they have some things written down, but I've not seen them."

This constituted a breach of Regulation 10 'Dignity and Respect' of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Respecting and promoting people's privacy, dignity and independence
• Staff did not always promote people's dignity and respect. We overheard some staff members talking about people's personal needs in a task focused manner. We observed other staff not being discreet when asking people about whether they needed to go to the toilet or be supported with personal care.
• The company directors failure to deploy enough staff meant that people's continence needs were not always met. Two people told us they had episodes of urinary incontinence because staff did not respond to their call bells promptly enough for them to be supported with dignity.
• Care records did not make clear the parts of tasks people could complete independently. This meant we were not assured that staff could support people in a way which upheld their dignity and respect.
• The environment did not promote people's dignity. The service was not consistently clean, with carpets stained with faeces in communal areas and some furnishings being in poor condition, meaning they could not be effectively cleaned. The bottom sheet on one person's bed was very worn, and the mattress underneath could be seen through it. Another person's bedding was stained. One person's room had a strong, unpleasant smell which had not been addressed and a light fitting in the main hallway was hanging off the ceiling.
• The décor in parts of the service was poor, particularly upstairs where wallpaper had been pulled off the wall and redecoration was required.

This constituted a breach of Regulation 10 'Dignity and Respect' of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

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 we identified that improvements were required. The service is now rated 'Inadequate' in this key question.

This meant services were not planned or delivered in ways that met people's needs.

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

• Care plans were not sufficiently personalised and did not contain sufficient information about people's past history, likes, dislikes, hobbies and interests. A number of people using the service were living with advanced dementia and may not be able to recall this information themselves. It was unclear how these people could be supported in a person-centred way.

• The service was using a high number of agency staff to fill it's shifts and was actively recruiting for significant numbers of new staff. We were not assured that these staff had access to sufficient information about people to deliver personalised care.

• Staff were not supported to understand behaviours they may find challenging. Many staff had not received training in this area to gain an understanding of how to de-escalate these situations.

• Staff and the registered manager demonstrated a poor understanding of why people living with dementia may display behaviours staff find challenging. People who liked to walk about the service were referred to as 'wanderers' or 'wandering'. This is an unhelpful term to use because it suggests there is no purpose to people's behaviours, when usually there is a purpose which has not been understood.

• Whilst care plans for some people did set out instructions for staff on how to respond when they displayed behaviours the service found challenging, for other people information did not make clear possible triggers.

• There was an over reliance on sedative medicines prescribed for people who had been prescribed these because they displayed behaviours on occasions that staff found challenging. Discussions with the registered manager and a review of medicines records meant we were not assured these were only administered as a last resort when all other interventions had failed.

• There was a lack of stimulation or engagement for people, particularly those who displayed behaviours staff found challenging. Attempts were not made to engage them in activity or for staff to spend time with them to fully understand their needs.

• The registered manager told us that they were currently recruiting for a member of activities staff, as their previous staff member had recently left. This meant there was limited provision for activities during our visit. The staffing level had not been adjusted to allow for extra staff time to engage people in meaningful activity.

• Whilst the registered manager told us about external entertainment they had sourced and other events they had arranged which were positive, there was a lack of consistent engagement for people at other times. One person told us, "We had someone doing things most days but now pretty much nothing goes on. I do get bored." Another person said, "It used to be pretty good with things to do but since [activities staff member] left I feel like we just sit here. Most people just sleep or sometimes they put music or the television on."

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

• People told us that the service supported them to maintain their relationships with relatives and friends. They told us their family and friends were free to visit at any time and dine with them.

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 were not provided with information in a way they could understand. For example, people living with dementia were not supported to make decisions in a visual way, such as being shown different meal options.
• Care plans required development to ensure they made clear how people could consent, be involved in decision making and communicate their needs effectively.
• Where people had limited verbal communication, there was little information for staff about the other ways they may communicate. For example, through facial expression or body language. For these people, some care plans stated staff should anticipate their needs, but with an absence of information about their past preferences this meant staff could make decisions which wouldn't be in line with their wishes.

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

End of life care and support
• Improvements were required to ensure that there were care plans reflecting people's wishes in coming to the end of their life.
• Where people were considered by healthcare professionals as coming to the end of their life, there were not always detailed enough care plans in place about how the service would meet their specific needs at this time. For one person, a discharge summary had stated further hospital admissions would not be in their best interests. However, this was not in their care plan so it was unclear how staff, particularly new and agency staff, would know this. Care plans that were in place did not reflect best practice guidance such as that produced by the Gold Standards Framework.

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

Improving care quality in response to complaints or concerns
• There was a complaints procedure in place which people told us they were aware of. People told us they knew how to complain. One said, "I would tell the registered manager."
• We reviewed the records of one complaint received this year and saw it was investigated and 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 Good. At this inspection significant shortfalls in the service were identified, and the service is now rated Inadequate in this key question.

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

- The registered manager and senior staff carried out a regular programme of audits, such as on infection control and medicines. However, these systems were not robust enough to identify all areas for improvement.
- Audits of falls did not analyse these for trends such as the time which falls were occurring. This meant they had not identified a trend in falls leading to serious injuries occurring mainly on the night shift.
- Audits were not being carried out of call bell response times. This meant they had not identified that staff were not answering people's requests for help promptly.
- A survey of the views of people using the service had not been completed recently and meetings had not been held. This meant that people did not have an opportunity to share their views and have a voice.
- Whilst a survey of relative's and staff views had been completed, this did not ask about their views on the staffing level. This meant an opportunity to identify issues staff and people told us about could've been missed.

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

- Notifications and referrals were made where appropriate. Services are required to make notifications to the Commission when certain incidents occur.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people and engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The inaction of the company directors meant that a culture of caring and respect was not promoted in the service.
- The company director's failure to deploy sufficient numbers of staff meant that people did not feel valued, felt that staff were not reliable and felt that their dignity was compromised because their needs were not met.
- People had not been given an opportunity to feedback on the quality of the service recently, and this meant that opportunities to identify shortfalls and dissatisfaction may have been missed.

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

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 and continuous learning and improving care

- The company directors did not promote a caring culture focused on driving high quality care for people. Negative comments were made about the behaviour of one of the company directors, and we observed that they did not always act in a professional manner. The company directors had not identified the impact of their behaviours on the overall culture of the service.
- The company directors had not ensured that they had adequate oversight of the quality of care provided to people. They did not have a robust quality assurance system in place to assess this and had not taken steps to gain a knowledge, understanding and experience of what good care looks like. This means they had been unable to identify the shortfalls we found.
- The company directors had not identified that the audit system the registered manager had in place was insufficient and ineffective. This meant no action had been taken to address this and the performance of the registered manager in identifying and managing risks.

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

- The company directors failed to notify us of a change to the company under which the service is registered.

This constituted a breach of the Care Quality Commission (Registration) Regulations 2009: Regulation 15

Working in partnership with others

- The management team had made links with external healthcare professionals such as the Falls Prevention Team and the Speech and Language Therapy Team. However, concerns were raised with us by other external healthcare bodies about the care provided to people.

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 15 Registration Regulations 2009 Notifications – notices of change 1.Subject to paragraph (2), the registered person must give notice in writing to the Commission, as soon as it is reasonably practicable to do so, if any of the following events takes place or is proposed to take place— e.where the service provider is a body other than a partnership— i.a change in the name or address of the body,

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care 1.The care and treatment of service users must— a.be appropriate, b.meet their needs, and c.reflect their preferences. 2.But paragraph (1) does not apply to the extent that the provision of care or treatment would result in a breach of regulation 11. 3.Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— a.carrying out, collaboratively with the relevant person, an assessment of the needs and preferences for care and treatment of the service user; b.designing care or treatment with a view to achieving service users' preferences and ensuring their needs are met; c.enabling and supporting relevant persons to understand the care or treatment choices

available to the service user and to discuss, with a competent health care professional or other competent person, the balance of risks and benefits involved in any particular course of treatment;
d.enabling and supporting relevant persons to make, or participate in making, decisions relating to the service user's care or treatment to the maximum extent possible;
e.providing opportunities for relevant persons to manage the service user's care or treatment;
f.involving relevant persons in decisions relating to the way in which the regulated activity is carried on in so far as it relates to the service user's care or treatment;

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect 1.Service users must be treated with dignity and respect. 2.Without limiting paragraph (1), the things which a registered person is required to do to comply with paragraph (1) include in particular— a.ensuring the privacy of the service user; b.supporting the autonomy, independence and involvement in the community of the service user;

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent 1.Care and treatment of service users must only be provided with the consent of the relevant person. 2.Paragraph (1) is subject to paragraphs (3) and (4). 3.If the service user is 16 or over and is unable to give such consent because they lack capacity to do so, the registered person must act in accordance with the 2005 Act*. 4.But if Part 4 or 4A of the 1983 Act** applies to

a service user, the registered person must act in accordance with the provisions of that Act.
5.Nothing in this regulation affects the operation of section 5 of the 2005 Act*, as read with section 6 of that Act (acts in connection with care or treatment).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs 1.The nutritional and hydration needs of service users must be met. 2.Paragraph (1) applies where— a.care or treatment involves— the provision of accommodation by the service provider, or an overnight stay for the service user on premises used by the service for the purposes of carrying on a regulated activity, or b.the meeting of the nutritional or hydration needs of service users is part of the arrangements made for the provision of care or treatment by the service provider.