Windsar Care Limited

Salt Hill Care Centre

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 well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Salt Hill Care Centre can accommodate up to 53 people (including couples) and provides nursing care, personal care and respite care to older and younger adults living with dementia, physical disabilities, learning disabilities and mental health support. At the time of our visit there were 51 people using the service.

People's experience of using this service and what we found
People and relatives said they were safe from abuse. Comments included, If she (family member) felt unsafe, she would speak to us or the (registered) manager" and "If I felt (family member) was unsafe I'd talk to the senior staff."

We found people were at risk of potential or actual abuse because appropriate action was not always taken when people sustained unexplained bruises. We have made a recommendation about this.

There were insufficient staff inappropriately deployed to support people who were assessed as highly dependent on staff to provide care and support to them. We have made a recommendation about this.

Medicine practices were not always safe as the service failed to follow its medicines policy and procedures. People, staff, and visitors were at risk of infection because the service did not do all that was possible to prevent it.

People received care and support that was not always, caring, person-centred and dignified. People received care and support from staff who were not always suitably qualified, skilled, and competent to meet their needs. People were not always supported to live healthier lives. This was because the service did not always work effectively with other healthcare services to meet their needs. People did not always receive nutritional snacks. We have made a recommendation about this.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; The registered manager did not work in accordance with the Mental Capacity Act 2005 and its Codes of Practice.

The design, decoration and adaptation of the building was not suitable for some people who lived there.

People received care and support from a service that did not always promote an open and empowering environment for people living with a learning disability, people living with dementia or people living in the service who were semi-dependent.

Quality assurance systems did not enable the provider to identify where quality and safety was being compromised and, learn when things went wrong. We have made a recommendation about the duty of

candour. There was no scrutiny at board level therefore, the provider failed to monitor progress against plans to improve the quality and safety of the service. Records relating to care and the management of the service, were not fit for purpose.

The service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture. This was because care and support did not always reflect current evidence-based guidance, standards, and best practice to meet the needs of people with a learning disability.

Right support: The service did not consider dementia as part of the care planning process other than to record it as a medical condition. This meant people did not get the individualised care and support needed.

Right care: People did not always receive person-centred care and support as staff were not always trained and competent to deliver care appropriately. Social activities were limited to the building and staff designated to provide entertainment did not have access to specialist training and appropriate resources. Care records were generic, illegible and did not consistently provide staff with enough information to know who and what were important to people.
Right culture: The culture of the service was not always inclusive, open, and empowering for people living a with a learning disability, autism, dementia, and complex health needs. This was because staff were not appropriately enrolled to role specific training to help enable them to work effectively. Quality assurance systems did not help the service to use lessons learned to improve quality and care for people using the service.

Rating at last inspection

The last rating for this service was good (published 23 August 2018).

Why we inspected
The inspection was prompted in part due to concerns raised by a local authority and concerns received relating to another of the provider's services. A decision was made for us to inspect and examine if there were similar risks at this service. So we widened the scope of the inspection to become a focused inspection which included the key questions of safe, effective and well-led. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

After our inspection the registered manager sent supporting evidence to show risks to people from faulty wheelchairs were now mitigated.

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

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively. This included checking the provider was meeting COVID-19 vaccination requirements.

The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, effective and well- led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Windsor Care Centre on our website at www.cqc.org.uk.

Enforcement and Recommendations
We are mindful of the impact of the 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 monitor the service and will take further action if needed.

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

We have identified breaches in relation to quality assurance; risk management; building and premises, consent, effective and person-centred care planning; management of medicine; infection control and staff training.

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

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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
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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 safe findings below.	**Requires Improvement**
Is the service well-led? he service was not well-led. Details are in our well-Led findings below	**Inadequate**

Salt Hill Care Centre

Detailed findings

Background to this 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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This included checking the provider was meeting COVID-19 vaccination requirements. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors, a pharmacist inspector, a specialist advisor who was an occupational therapist and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Salt Hill Care Centre is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 18 August 2022 and ended on 1 September 22 August 2022. We visited the service on 17 August 2022 and 1 September 2022. The Expert by Experience conducted telephone interviews with eight relatives, a family friend and an advocate on 19 August 2022 and an inspector conducted telephone interviews with two staff members on 22 August 2022.

What we did before the inspection
The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is

information providers send us to give some key information about the service, what the service does well and improvements they plan to make. Feedback of concerns about the service was received from a local authority and other information of concern received was included in the planning of this inspection.

During the inspection
We spoke with eight relatives, three people who used the service, two cleaners, two kitchen assistants, the chef, maintenance person, seven care workers, two activity coordinators, two registered nurses, a visiting health physiotherapist assistant and the registered manager who also acted as the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We looked in detail at 11 care plans, nine medicine administration records, two staff recruitment files and the service's staff training matrix. We looked at a variety of records relating to the management of the service, this also included the service's policies and procedures.

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After the inspection
We conducted telephone interviews with eight relatives, two people who visited people as a family friend and an advocate, and two staff members to gather further feedback about the service. We continued to seek clarification from the provider to validate evidence found. All information received was used as part of our inspection.

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 Good. At this inspection the key was rating has changed to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- People had personal emergency evacuation plans (PEEPs) completed and these were in reception in case of an emergency, for example a fire. However, these were not up to date, contained insufficient information about equipment and staff required, and how the person would be moved to safety. The registered manager had an updated template and stated they were in the process of completing new PEEPs.
- Kitchenettes on each floor contained harmful substances and chemicals under the sink. The cupboard doors were not locked and easily accessible to people. There was a risk they could be ingested.
- In another unlocked cupboard, we found a person's fluid thickening powder. This is used for people at risk of choking. However, the powder must be securely stored away as if ingested without mixing with fluid, it can cause choking.
- Risk assessments and care plans for people with behaviours that challenge contained insufficient details to guide staff on how to manage this. Behaviour charts were not routinely used to determine the cause, frequency, triggers of behaviours and what may work to help calm or soothe the person.
- Where people were known to display verbal or physical distressed behaviours, risk assessments and risk management plans were not always in place. For example, a staff member told us a person could get, 'aggressive really quick", we viewed the person's care records and found no record that reflected this. Instead it stated the person could get up when staff did certain things. However, it did not say what behaviour was displayed and what staff should do to de-escalate it.
- We found several examples of people with identified risks, such as falling, with either no appropriate plans to mitigate those risks or with no risk assessments in place. One person had been assessed at very high risk of falls. A falls risk assessment was in place and was last updated on 2 August 2022. However, there was no sensor mat or low bed as recommended in the falls risk assessment. Another person with poor mobility had a moving and handling risk assessment instructing staff how to safely support the person when transferring to and from bed and chair. However, there was no completed falls risk assessment to prevent unavoidable harm.

We found no evidence people were harmed but, the service did not do all that was reasonably practicable to protect people from unavoidable harm. This was a breach of Regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- Routine checks of fire safety were completed, and the fire service had inspected the service in 2022, documenting there was an 'adequate' level of safety. There was a contractor for Legionella prevention and control. Legionella had been detected in the water system; however, it was not the type that routinely causes respiratory disease and the provider had a management plan in place.
- People and relatives could not remember seeing risk assessments but several felt able to comment

generally about how well the home supported their loved one in following safety measures such as using equipment to mobilise. Staff said they felt confident to do their job and were aware of incident reporting.

Staffing and recruitment

● During our inspection a person in their bedroom, near a staff station, was calling out for assistance to use the bathroom and was very distressed. A cleaner entered their room to carry out cleaning but paid no attention to them. When the inspection team intervened, their call bell had been alarming for three to four minutes, but no staff came to assist the person.

● A registered nurse was administering medicines at the time and the two remaining care staff on the shift were busy delivering care. One of the care workers eventually entered the person's room to tell them they were attending to someone else and would be there soon. The person was not happy with this response and stated they really needed the commode. This meant people did not always get appropriate assistance when required to meet their needs.

● Although the provider used a 'dependency tool' to calculate staffing hours, insufficient staff were deployed to safely meet people's needs. The tool did not effectively consider people who required two care workers for moving and handling or personal care, environmental factors such as the layout of the building, or people who walked with purpose around each floor. Therefore we were not assured staffing levels were sufficient to meet people's needs.

● Some staff felt staffing levels were poor. For example, a staff member commented, "No! (not enough staff) two carers is not adequate because we have a lot of people with high dependency needs and people who walk with purpose."

● The registered manager told us they had designated one nurse and two care workers for each floor. This was supported by the staff rota viewed.

● A review of one person's care plan showed It was recommended to keep their door open and supervise them at all times. However we observed the person falling out of their bed, left unsupervised, with the door almost closed. We found the staffing levels did not support people who required supervision.

We found no evidence people were harmed. However, there was a potential risk of harm because there were insufficient numbers of staff suitably deployed to meet people's care and support needs. This demonstrates a breach of Regulation 18 (Staffing) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider's recruitment process did not always ensure only 'fit and proper' persons were employed. Most of the required checks were completed, such as criminal record checks and proof of good conduct in prior roles. There were some gaps in employment history and checks of conduct were gained from people who were not the employee's prior line manager or from a human resources department. Interview questions for care workers and registered nurses were too basic and did not ensure enough information was gathered to demonstrate the applicant had the knowledge, skills and experience for their role.

● Checks of nurses' registrations and renewals were completed to ensure they were legally entitled to practice.

We recommend the service seek current guidance and best practice to ensure all relevant recruitment checks are completed.

Using medicines safely

● Medicine practices were not always safe as staff failed to follow the provider's medicines policy and procedures.

● Medicines were generally stored securely, and records demonstrated that the room temperature where

medicines were stored was monitored regularly. There were records to demonstrate that staff regularly monitored the temperature of the medicine's fridge. However, on the day of inspection we found that medicines requiring refrigeration were not kept within their recommended temperature range. Therefore, we could not be assured that these medicines would be effective when administered.

● Whilst most people using the service had one or more medicines prescribed to be administered 'as and when' required (PRN), person specific guidance was not in place to aid staff when making decisions to administer. Therefore, we were not assured staff had the information they needed to appropriately administer these medicines to meet people's needs. This included medicines for anxiety for people who were unable to verbally communicate how they were feeling.

● When PRN medicines were administered, staff did not consistently record the time, reason and outcome for the person receiving the medicine. This meant that the effectiveness of the medicine could not be reviewed.

● One person was prescribed medicines for anxiety as PRN. However, it was being administered as a regular dose. Another person was prescribed a medicine to be administered daily. However, staff were administering this as PRN. This demonstrated that staff did not always understand what medicines were for and were not administering these medicines appropriately.

● People who were prescribed topical medicines had records of where to apply creams and administer eye drops. However, we saw that multiple topical medicines were recorded on the same body map. It was not always clear to staff which creams should be applied where. Therefore we could not be assured that staff were applying each of the topical medicines as prescribed.

● Some people were administered medicines covertly (when medicines are administered in a disguised format). However, we saw one person was being administered medicines covertly where the appropriate legal framework had not been followed in line with the Mental Capacity Act 2005. Therefore we could not be assured that medicines were being administered in the best interests of the person.

● Medicines audits were conducted monthly to check if medicines were managed safely, however issues we identified were not found as part of the audit.

We found no evidence people were harmed but unsafe medicines practices placed people at potential risk of harm. This demonstrates a breach of Regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● We saw staff who administered medicines had received formal supervision to ensure they were competent to administer medicines.

Preventing and controlling infection

● People, staff and visitors were at risk of infection because the service did not do all that was possible to prevent it.

● Although cleaners were working, most areas were not cleaned to an appropriate standard. There was debris and dirt found in various areas such as kitchenettes, behind chairs and under cushions, in communal bathrooms and toilets. Splash marks from drinks and body fluids were found on the walls.

● Clean and dirty items were not effectively separated to prevent cross contamination. For example, boxes or packets of personal protective equipment (PPE) were stored on dirty benches in sluice rooms, next to rubbish or beside sharps bins.

● Insufficient storage facilities led to clean linen, such as pillows, sheets and duvets being stored on the floor in linen closets.

● Cleaners failed to follow best practice guidance in relation to cleanliness. This requires certain coloured mops, buckets and clothes to be used for cleaning different parts of the building, such as floors, bathrooms and seating. They were observed using the same mop or cloth to clean different areas, increasing the

chances of spreading bacteria and viruses.
● Some bathrooms and sluice rooms contained odours. Sluice rooms and some bathrooms had dirty or broken equipment stored in them, which made it more difficult to clean.
● Cleaning trolleys were soiled, some bins were damaged and required replacement, and used sharps bins were in open linen closets.
● Some painted surfaces throughout the building were so worn or damaged that they could not be effectively cleaned to a suitable standard.
● Medicines cups and syringes were found draining on top of a radiator in the dining room, despite locked medicines rooms being available. We informed a registered nurse, who then discarded them.
● We were not assured that the provider was always accessing COVID-19 testing for people using the service and staff consistently. Some staff we spoke with confirmed that they had not tested or provided lateral flow results on multiple occasions. They were not challenged by management to ensure they had completed testing in line with guidance at the time.

People were placed at risk of harm from infections, because hygiene standards were inadequate. This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● Staff were observed to use PPE correctly, including face masks. The provider's infection prevention and control policy was up to date.
● There were no reported restrictions to visiting arrangements.
● People were encouraged to take up routine vaccinations, such as those for respiratory diseases.

Learning lessons when things go wrong
● Analysis of accidents and incidents were not effective in identifying, any trends or patterns to enable the service to make improvements to people's safety. An analysis of accidents and incidents conducted for the month of February 2022, documented the names of people who had a fall. We noted some people had repeated falls, one person was noted to have had two falls and another person three falls, all within a short period of time.
● The report showed a common factor for all the falls in February was that everyone was found on the floor. Possible causes were summarised as, people had lost balance trying to get out of their beds. We noted not everyone who had a fall in the month of February, fell due to trying to get out of bed. The report failed to consider other factor such as, time of the day people fell or if their health conditions played a part in their falls. Therefore we could not be assured the provider was taking action to mitigate risks to people's safety appropriately.
● Medicines audits were conducted monthly to check if medicines were managed safely, however issues we identified were not found as part of the audit.
● We reviewed a statutory notification with the registered manager to assess how they learn from a recent safeguarding incident. The registered manager informed us they had spoken to relevant staff members to share learning but could not evidence this as their discussions had not been recorded. Therefore they were unable to demonstrate any improvements they had made.

Systems in place did not enable the service to effectively identify and learn when thing went wrong. This was a breach of Regulation 17 Good Governance of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
●Safeguarding practices did not always ensure staff identified, prevented and reported potential abuse. For example, care records showed a person had suffered an unexplained injury, a cut to their head. Although

staff took appropriate action and treated the person, there was no record of what action staff had taken to find out how the injury occurred and, it was not reported to the local authority.

We recommend the service follow its safeguarding policy and procedure, and seek current best practice and national guidance to ensure appropriate action is taken when unexplained injuries happen.

● People and relatives said they were safe from abuse. Comments included, "Totally (safe), because they're extremely good at caring for (family member) who has very complex needs. If she felt unsafe she would speak to us or the (registered) manager" and "If I felt (family member) was unsafe I'd talk to the senior staff."
● Staff said they had attended relevant training and had to report all concerns to the registered manager.

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.

This key question has been rated Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- People received care and support that was not always, caring, person-centred and dignified. There were activities coordinators present on some floors who attempted to engage people and provide social stimulation. However, we observed they did not ask people what activities they wanted to do.
- The activities coordinators had not completed any relevant training to provide them with knowledge and skills to promote social integration and appropriate stimulation for people living with dementia. At the site visit, no one (except those who smoked) left their bedrooms or communal lounge areas to take part in any activities.
- Pop music played on a TV in the background in communal lounges. It was loud and distracting, and hindered people having meaningful conversations with each other or staff. Staff had to raise their voices to speak with people.
- The activities coordinators quickly changed activities from skittles, to puzzles, to singing nursery rhymes, which was undignified and not suitable for people living with dementia. Insufficient time and explanation were provided for people to engage in each activity. Some people were not included in the activities.
- Some people walked with purpose, as they lived with dementia. They were observed to walk around the unit in a circular fashion, and without staff interacting with them. Staff were observed to walk past them, not interact with them, and left them to continue with whatever they were doing at the time.
- One person was observed to be picking at other people's bedroom signage. Another was walking around the corridor looking at walls. Another person, in a bedroom, was standing with socks on and playing with the duvet cover repeatedly. There was no staff interaction with these people until lunch was served.
- One person sat for several hours in the darkness of a communal lounge in the basement. There was a TV turned on in the corner of the room but when spoken to, the person said they were bored.
- A person received a telephone call from their relative. They used a cordless handset. However, they were observed to shout repeatedly that they could not hear the caller. Staff did not take action to assist the person. For example, by placing the handset on speaker or relaying information between the caller and the person to allow them to engage in a meaningful conversation with their relative.
- A person was hoisted from a wheelchair to a chair in the lounge by two staff. They did not explain to the person what steps they were taking, and the person was confused, shouting, and swearing loudly in front of others. Staff did not stop and try again later, or first attempt reassurance. Instead, they continued with the hoist whilst the person was shouting and swearing, and until the person was in the lounge chair.

Staff did not work consistently to make sure people received person-centred care and support that was appropriate and meet their needs. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● People and relatives did provide positive feedback about the care and support received.
● We observed some caring interactions between some staff and people. For example, a staff member communicated with a person using the appropriate tone and language to encourage them to engage.

Staff support: induction, training, skills and experience
● People received care and support from staff who were not always suitably qualified, skilled, and competent to meet their needs. Staff training matrices showed most staff had not completed or renewed all the statutory and mandatory training required. This would have ensured they had the correct knowledge and skills for them to perform their roles safely and effectively.
● Areas of high risk, such as fire safety, practical moving and handling, medicines management and falls prevention had the lowest completion rates. This placed people at risk of harm as staff had not completed the training they needed and were not assessed as competent in these topics.
● Staff training and development plans were not designed around people with learning disabilities and, mental health conditions and people living with dementia.

The service did not always ensure staff were suitably qualified, skilled and competent to meet people's care and support needs. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● People were not always offered a variety of nutritious snacks throughout the day that would also take into consideration people who would prefer to eat 'little and often'. Therefore we could not be assured people's needs in relation to their diet and nutrition were being met.
● At our prior inspection, we recommended the service considered steps it could take to improve the provision of snacks for people. We noted during morning and afternoon tea people were offered biscuits or other baked good, but snacks of higher nutritional value such as fruit was not provided.
● A person commented, "The food is not good in the care home", and expressed it could be improved to give people choice and said it should be, "more nutritious."
● Menus were displayed on walls on each floor. There were some pictures, although the signage was small and symbols were not used to help people living with dementia, who may not understand the words.
● There was more than one meal choice, although people were not asked or shown plated food so they could actively take part in their meal service. Staff plated the food and served it to them or assisted them with eating if needed. Staff did not offer alternatives if the person appeared disinterested in the meal they were provided.
● Drinks and cups were available on tables near kitchenettes on each floor. People had drinks offered at specific times, such as morning tea and lunch. Apart from this, staff were not observed to encourage people to consume fluids regularly to prevent dehydration.

We recommend the service seek current guidance and best practice in relation to providing snacks with sufficient nutritional value.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People were not always supported to live healthier lives because the service did not always work effectively with other healthcare services to meet their needs.
● We spoke with a visiting Physiotherapy assistant who was supporting a person who had poor mobility. This visit did not happen on a frequent basis. Staff were not involved in the person's program as the physiotherapist did not believe the had the relevant skills.

● We were told the person was making improvements and found out the exercise the person engaged in, was the type of exercise the person could easily do if they were in their own home. This meant, there was no agreed joint working, to enable care workers to assist to enable a continuous re-enablement process and reduce the person's risk of falls.
● We reviewed the care records of several people who were assessed at high to medium risk of falls. Care records showed physiotherapy input was not sought or considered.

There was no pro-active plan in place by the service to form working partnerships with the aim of improving the lives of people with poor mobility and people's care needs were not regularly reviewed. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● A GP visited regularly, and staff could record in advance of the GP rounds any people that needed assessment. Out of hours calls to healthcare professionals were also used by staff.
● Other healthcare professionals such as dentists, podiatrists, tissue viability nurses and occupational therapists, were used to ensure people maintained a healthy lifestyle.

Adapting service, design, decoration to meet people's needs
● The design, decoration and adaptation of the building was not suitable for some people who lived there. Many people lived with dementia and were accommodated across several floors; some that were not adapted to their needs.
● No assessment was undertaken to ensure the environment was dementia friendly. Simple premises principles from best practice guidance were not used to promote a suitable living experience.
● Some corridors were poorly lit, and bright white fluorescent lighting was used in most areas. Poorly lit corridors increased the risk of trips and falls, and harsh bright light is not recommended for people living with dementia.
● On the lower ground floor, a previous water leak had caused extensive damage to the floor covering. It was raised and had uneven surfaces throughout. This was noted as the inspection team walked throughout the area. This created a trip and slip hazard for people, as the floor also had poorly lit corridors. The registered manager stated the floor was being replaced. However, they had not mitigated the risk to people from the uneven floor covering, for example by entirely removing it until it was replaced.
● Kitchenettes on all four floors were observed to be heavily damaged, beyond repair and a risk to both people and staff. Countertops were worn, cupboard doors were poorly attached or falling off, a microwave and a fridge were not functioning adequately, and shelving was water damaged. We asked the registered manager to take urgent action to remedy the kitchenette areas. They stated they would organise prompt replacement. We returned to the service for a second day, and noted the kitchenette cabinets, worktops, a fridge and a microwave were replaced.
● Several sections of the building required certain doors to be locked to prevent avoidable harm to people. However, we found the doors were almost always unlocked and easily accessible. This included sluice rooms, storage rooms, the lift motor room, and cleaning supply rooms. There was a risk of injury from sharps, chemicals, equipment or electrical installations. The registered manager was informed so the doors could be secured.
● Some other equipment and fixtures were also not repaired to a satisfactory standard. Radiator covers were observed to be missing parts. Hazard tape was used to cover some items or hold them together. Some bathrooms had peeling paint and certain rooms, equipment and linen trolleys were visibly rusty.
● On one floor posters, signage and suitable items were attached to the walls for people living with dementia. This included items for people to touch and feel or interact with. However, these were not maintained to a suitable standard. Several of the posters were ripped and other items were damaged or

dirty.

The registered person failed to ensure the premises and equipment were adequately adapted, decorated and maintained to ensure people's safety and welfare. This was a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● There was a wheelchair accessible lift between floors, and a ramp at the front of the building for people with mobility impairments.

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 MCA 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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● People who were not able to make specific decision were not always protected. This was because consent was not always obtained, documented, and reviewed in line with the law.
● Mental capacity assessments were completed. Capacity to make decisions must be presumed unless proven otherwise. Some people had capacity assessments completed when they did not require them as they could make relevant decisions for themselves. Staff had adopted an approach that everyone required capacity assessments, contrary to the code of practice set out in the MCA.
● Relevant mental capacity assessments contained enough details to help determine whether a person could make a specific decision. However, they did not always contain information about who else was consulted during the assessment process. Some contained information about relatives' or healthcare professionals' involvement, but this was not consistent.
● People assessed as lacking mental capacity had best interests decision documentation in place. These contained sufficient details. However, best interest decision tools were used for multiple decisions at one time; the MCA code of practice requires the process to be both decision and time specific. This means multiple decisions cannot be made within one best interests decision-making process.
● The administration and management maintained a list of people who had legally appointed attorneys for health and welfare, finance or both and if there was a Court of Protection appointed attorney. However, this information was not reflected in care documentation on the units.
● 'Next of kin' (for example relatives) who were not legally appointed by the Office of the Public Guardian via a valid an enduring or lasting power of attorney, were often used by staff as decision-makers for people who lacked capacity. Third parties cannot make healthcare decisions on other people's behalf unless they can do so legally.
● Some people had their medicines given covertly (in food or drinks). There was not always a best interest decision in place for this administration method.
● There was a list of people who had applications for, existing or lapsed DoLS authorisations in place. Many

were outstanding for long periods of time, including applications from 2018 and 2020. However, there were no recorded attempts by the staff to seek the status of the applications from the local authorities.

The registered person failed to ensure consent was correctly established in accordance with the Mental Capacity Act 2005. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

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

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

- People received care and support from a service that did not always promote an open and empowering environment for people with a learning disability, living with dementia or people living in the service who were semi-dependent.
- Autistic people and people with a learning disability are as entitled to live an ordinary life as any other citizen. We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted.
- Care and support did not always reflect current evidence-based guidance, standards and best practice to meet the needs of people with a learning disability, living with dementia and people living in the service who were semi-dependent.
- People were not supported to follow their interests and take part in activities in their local community.
- Staff were not adequately trained to meet people living with learning disabilities care and support needs and had limited knowledge. For example, a staff member was not aware of what type of learning disability a person had although they had been working with the person for a while.
- Another staff member was engaged in an activity with people who were living with dementia. They were not able to demonstrate a basic awareness of dementia and people were spoken to in a 'child-like' manner.
- Where people were semi-independent, there were no planned programme in place to support them to be able to go back to independent living. We observed people either remained in their rooms all day or would go out into the community. There was no goal planning and the only interaction we observed was, a registered nurse administering their medicines.
- The service did not develop positive behaviour support plans (PBS). This a person-centred framework for providing long-term support to people with a learning disability, and/or autism, including those with mental health conditions whose behaviour may change when they are distressed or unable to express themselves. This would have enabled staff to understand the reason for people's behaviour so they could meet their needs and enhance their quality of life.
- The service sought feedback from relatives and staff in June and July 2021. Most feedback was positive from relatives and staff. However, where further suggestions were made such as, improving activities for people, these were not reviewed to evaluate how effective any changes in response to feedback were. We were not able to see improvements with activities during our inspection.

There were not effective systems in place to enable the provider to identify where quality and safety was being compromised. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Quality assurance systems used to assess, monitor and improve service delivery were inadequate.

● The 'Quality Oversight Group' meetings held at board level to ensure quality assurance systems in place remained effective, had stopped since 7 May 2021, due to the COVID-19 pandemic. This meant there was no overall scrutiny of the service. The registered manager told us these meetings were going to resume shortly.

● The deputy manager had left employment and was not replaced although a registered nurse was being used in a 'unit manager' capacity. There was no clear expectation for the registered nurse to oversee the management of the home in the registered manager's absence. Furthermore, there was no evidence the registered manager was recruiting to the position; they were unable to provide information to show the role was advertised, applications were received, or interviews were planned or had occurred.

● The registered manager also managed another nursing home nearby, where they were supported by a deputy manager. However, they were also the nominated individual for a total of four nursing homes. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

● The registered manager was not job sharing their role. The combination of the roles as registered manager and nominated individual, and oversight of up to 245 beds, meant they had insufficient time to perform their roles to a satisfactory standard. There was no quality or compliance manager or support, and no one else deployed to assist with ensuring the safety and quality of the service.

● Audits undertaken did not identify the concerns we found with care plans, staff training, managing and assessing risks, medicine and staffing. This demonstrated the need for further role specific training for the registered manager and those who held supervisory roles.

● Dependency assessment data did not translate to additional staff when people's dependency needs were re-assessed as high. Therefore people's needs were not always met.

● People and relatives felt further improvements were required. The service had a schedule of activities for people held from Mondays to Fridays, with no activity schedules in place for people who were not able to leave their rooms and there were no scheduled activities at weekends.

● Records relating to care and the management of the service were at times, illegible and not fully completed. Falls risk assessments and falls management plans were generic, not person-centred and did not give a clear picture of what action had been taken by staff, over-time, to manage or mitigate risks.

The provider failed to monitor progress against plans to improve the quality and safety of the service and records relating to care and the management of the service, were not completed as expected. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People and, relatives felt the service was well-led and staff felt the registered manager was approachable and supportive.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

●The CQC sets out specific requirements that providers must follow when things go wrong with care and treatment. This includes informing people and their relatives about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

● Although duty of candour letters was sent when things went wrong. The registered manager would need

to ensure this these are sent out in a timely manner and ensure all aspects of the legislation is met.

We recommend the provider ensure work practices are in line with their Duty of Candour Policy.

Working in partnership with others

● The service worked in partnership with a range of health and social care services. However, further improvement was required for the service to established stronger partnership with specialist health services to ensure people's care and support needs are effectively met.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Staff did not work consistently to make sure people received person-centred care and support that was appropriate and meet their needs. There was no pro-active plan in place to form working partnerships with health and social care service to improve the lives of people living who had poor mobility and people's care needs were not regularly reviewed. Regulation 9 (3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person failed to ensure consent was correctly established in accordance with the Mental Capacity Act 2005. Regulation (11), (1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The registered person failed to ensure the premises and equipment were adequately adapted, decorated, and maintained to ensure people's safety and welfare. Regulation (15) (1), (c).