Valley View Care Home Ltd

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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
Valley View Care Home Ltd is a residential care home providing accommodation for persons who require nursing or personal care to up to 33 people. The service provides support to older people, some of who lived with dementia. At the time of our inspection there were 32 people using the service.

People's experience of using this service and what we found
Risks to people's safety had not always been identified. Risk assessments did not have all the information staff needed to keep people safe. Medicines management was poor. The provider could not be assured that people had received their medicines as prescribed.

The service was not always well led. Records were not always robust and accurate. The provider had failed to identify issues relating to risk assessments, staff recruitment, safeguarding, mental capacity and medicines management. Their quality monitoring processes had not identified issues with records that we found on inspection.

Assessments of staffing levels were undertaken by the registered manager. However, it was not clear how the data collected informed the staffing rota. There were not enough staff deployed to provide safe care in the afternoon and at night. People told us this meant they had to wait for care, and they were sometimes incontinent as a result.

Staff understood their responsibilities to protect people from abuse. Staff described what abuse meant and told us how they would respond and report if they witnessed anything untoward. However, staff had not always identified and reported potential abuse appropriately.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Most staff had received training relevant to their roles, however some staff required training in catheter care and fire drills to make sure they could meet people's needs effectively.

Despite the feedback above, people and relatives told us staff were kind, caring and friendly. Comments included, "I like them"; "Very friendly, I can't complain"; "They are friendly, helpful and knowledgeable. If I am concerned about something, I can go to any of them and ask questions. I can ring as well"; "They are kind. They say hello and look after me"; "I have my privacy" and "They shut the door when changing me."

Staff had been recruited safely to ensure they were suitable to work with people. People had regular staff who they knew well.

We were assured that the provider was admitting people safely to the service. We were assured that the provider was using personal protective equipment effectively and safely. The service was clean.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 22 September 2021) and there were breaches of regulation. We took enforcement action and served the provider conditions on their registration. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection we found the provider remained in breach of regulations. The service has now been rated inadequate. This service has not been rated good for the last five consecutive inspections.

At our last inspection we recommended that the provider sought advice from a reputable source, to suitably assess the numbers of staff needed to meet people's needs and aid the deployment of staff. At this inspection we found the provider had not acted on the recommendation.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection. We received concerns in relation to the management of medicines. As a result, we undertook a focused inspection to review the key questions of safe and well-led. As we found a breach of regulation in relation to mental capacity and DoLS we extended the inspection to include the effective domain.

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.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection. You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement
We have identified breaches in relation to safeguarding people from abuse, risk management, medicines management, staff deployment, mental capacity and DoLS, failure to provide care and treatment to meet people's assessed needs, continuous improvement, informing CQC about notifiable events and good governance at this inspection.

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

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 meet with the provider following this report being published to discuss how they will make changes

to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Valley View Care Home Ltd

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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. 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
This inspection was carried out by 3 inspectors (including a medicines inspector) 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
Valley View Care Home Ltd 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. Valley View Care Home Ltd is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection

This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We gained feedback from the local authorities and other professionals who work with the service. We also sought feedback from Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. Healthwatch told us they had not visited the service or received any comments or concerns since the last inspection.

We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 9 people who used the service, 3 relatives and 3 visitors (one of whom was visiting in a professional capacity) about their experience of the care provided. We observed staff interactions with people and their care and support in communal areas. We spoke with 9 members of staff including the nominated individual, the registered manager, nurses, senior care workers and care workers. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included 10 people's care records and multiple medication records. We looked at 3 files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People were not always protected from the risk of abuse. When people's continence needs had been neglected (which was a safeguarding concern), this had not always been appropriately identified, reported and dealt with. The local authority and CQC had not been informed.
- Staff told us they felt comfortable to report concerns to the provider and registered manager. They felt that concerns were taken seriously, and appropriate action would be taken. Staff knew how to escalate concerns to outside organisations such as the local authority safeguarding team and CQC if necessary. One staff member said, "I would report safeguarding to the senior, log it in a report and I would write who I reported it to. I would report to [registered manager] and reassure the resident. I could report to [nominated individual], I could report to the council and CQC." However, staff had not always identified neglect as abuse and reported safeguarding incidents of neglect (relating to support with continence care) to the management team.

Registered persons had failed to protect people from abuse and improper treatment. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

- Despite our findings. People told us they felt safe. Comments included, "Honestly, I could not feel more safe. I could not be more better looked after" and "They make me feel safe."

Assessing risk, safety monitoring and management

At our last inspection, the provider had failed to ensure risks were robustly identified and managed to prevent harm and failed to consistently monitor incidents to learn lessons and mitigate individual risks. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- At our last inspection, fire safety risks had not always been assessed and well managed. At this inspection, fire safety had improved. However, fire evacuation lists had not been updated when there had been changes, for example, five people were not listed on the evacuation list. Not all staff working at the service had completed a fire drill in the last 12 months, and this increased the risks to people in the event of an emergency.
- At our last inspection, risk assessments did not always provide clear guidance to staff about how to meet

people's needs safely. At this inspection, this remained the same. One person who was cared for in bed had a risk assessment which identified a risk of not being able to use a call bell and not being able to make their needs known. The risk assessment stated that staff needed to check on them regularly to ensure they were safe and comfortable. The risk assessment did not give any indication how often 'regularly' meant. The person's care records did not show that staff had been making frequent or regular checks on them. The call bell was still in the room with a sign near it stating do not use. Two staff told us during the inspection that the person could not use a call bell because they had been found with the call bell lead around their neck and therefore there was a ligature risk. There was no mention of this anywhere in the person's risk assessments or bedroom. Other staff did not know about the risk of ligature. This meant there was a potential risk of new and agency staff not having all the information they needed to provide safe care.

● Risk assessments relating to people living with epilepsy did not include important information about how to support people safely during bath time and other risks associated with epilepsy such as SUDEP. SUDEP (Sudden unexpected death in epilepsy). Epilepsy risk assessments were not person centred and did not provide detail on how to work safely with people. One person's stated that the way to mitigate risks to the person would be to check them hourly when they were in bed. However, checking the person would not prevent them from having a seizure. The provider had not considered other equipment such as bed monitors to help keep people safe and monitor seizure activity more effectively. This put people living with epilepsy at risk of harm.

● Bed rails risk assessments were in place; however, these were not specific and clear. There was no evidence that bed rails assessments had been carried out to determine that bed rails were suitable for the type of bed and mattress. Nursing staff responsible for carrying out risk assessments were unaware of the need to assess bed rail suitability following Health and Safety Executive guidance. We shared this guidance with them to enable them to make changes to ensure bed rails were suitable for the beds they were being used on.

● Choking risks had not been well managed. One person's eating and drinking care plan and risk assessments had not been updated when their assessed needs had changed. The person had been assessed by speech and language therapy on 9 November 2022 and required a modified diet and thickened fluids.. The person had received food and fluids to meet their current needs. However, there was a potential risk of new or agency staff not having all the information they needed to work safely with the person and put them at risk of choking

● At the last inspection risks around constipation were not well managed. At this inspection, these risks remained, and continence care risks had not been well managed. One person had not opened their bowels for a period of 18 days. No action had been taken to offer the person laxative medicine until they had gone 14 days without a bowel motion. Timely action had not been taken to refer the person on to their GP.

● Staff supported people with catheter care. Risk assessments relating to catheter care were not clear. For example, guidance on catheter hygiene had not been included as well as information about how frequently to change the catheter. There was no information about what the signs of infection were. This meant staff did not have all the information they needed to provide safe care.

● One person's care records evidenced they had been agitated and distressed and had been spitting at staff, spitting out medicines and food. There was no guidance for staff on how to support the person during incidents of distress and how to work safely. A risk assessment to identify that additional personal protective equipment was required had not been completed. This meant staff were at an increased risk of developing a healthcare related infection.

The failure to ensure risks were robustly identified and managed to prevent harm so people received safe care is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At our last inspection, the provider had not always recruited safely to ensure staff were suitable to work with people. This was a breach of Regulation 19 (Fit and proper persons employed) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 19.

● We found insufficient staff numbers were deployed in order to keep people safe. We observed there to be enough staff around supporting people in the mornings. However, in the afternoon only two care staff were on shift on each floor, plus a senior care staff and a nurse for the whole service. We observed people sat in communal areas between 18:00 and 19:00, they were calling out for staff to take them back to their rooms or to the toilet, no staff were deployed to monitor communal areas when these were in use. There were 25 people across the service who required two staff to support them with personal care, repositioning and continence care. This left no care staff available in communal areas to respond to people's needs and call bells when the nurse and senior care staff were completing the medicines round or when the nurse was tied up with nursing tasks.
● People told us there are sometimes long delays in getting care needs met when they pressed their call bells. Some people told us they had limited contact with staff as it is based on tasks only. Staff told us the same. People said, "They [staff] are in [to bedroom] for two minutes and off to see other people, they try hard. Don't get time to chat. They do what they have got to do and they clear off"; "At night there are two [staff] on. I called for the commode at 20:30 and they came at 22:30. They carried on doing the drinks"; "Sometimes I am waiting around a lot"; "I have a buzzer. The buzzer is working. I have to wait, always have to wait. If I have taken a laxative, I do it in the bed"; "I have to wait. I just sort of wait. If they are busy sometimes I have an accident, upset stomach."
● We did not observe night practice. However, rotas showed there were only two care staff and one nurse on shift at night. The provider had a dependency tool in place to determine safe staffing levels, however, it was not clear as to how the dependency scores were then utilised to inform the rota for afternoons and nights. Staff who worked the morning part of a day shift told us they were still supporting people to get up and washed at lunchtime, they had little time to make records of what care and supported they had provided. They told us they completed the records after lunch. Some staff reported that this led to staff forgetting to note down important information such as people's fluid intake or bowel motions.

The failure to ensure sufficient, skilled staff are deployed to keep people safe is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

● At the last inspection, the provider had not always carried out checks to explore staff members' employment history. At this inspection, the provider had carried out thorough recruitment checks. They continued to ensure staff were vetted through the Disclosure and Barring Service (DBS) before they started work and records were kept of these checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. Nurses were registered with the Nursing and Midwifery Council and the provider had made checks on their PIN numbers to confirm their registration status.

Using medicines safely

At our last inspection, the provider failed to take appropriate actions to ensure medicines were managed in a safe way. This was a continued breach of Regulation 12 (Safe Care and Treatment) of the Health and Social

Care Act 2008 (Regulated Activities) Regulations 2014.

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

● At the last inspection, medicines in stock did not balance with the medicines administration records (MAR) and stock sheets. At this inspection, the management of risk and medicines was ineffective and placed people at risk of harm. Medicines were not always available. Where there were stock shortages, there was a delay in the medicines being delivered which was led to people going without their medicines sometimes for a few days. One person had gone without their medicines for several weeks, which had impacted on their health and comfort.
● At the last inspection, there was an issue with medicated pain patch application and recording. At this inspection, Staff had received medicines administration training, however people did not always receive their medicines safely. Staff used a paper-based medicines administration system (MAR) however, hand written records were not always clear and legible, this increased the risks of wrong doses being administered. Staff were not always following the prescriber's and manufacturer's instructions, which increased the risks of side effects or overdose.
● Documents to support staff in the use of PRN (when required) medicines were not always detailed enough to support staff to assess when or how much medicine to give people. Where people were prescribed a variable dose, there was no information to support staff in making a decision about the quantity to give. This increased the risks of side effects or overdose.
● Care plans did not always contain up to date information and staff were not always made aware when changes were made to people's care needs. Care plans were not person centred and lacked detail about how to manage people's medicines safely. Risk assessments were not always in place for people in relation to medicines risks.
● The service worked with GP's, mental health and diabetes teams. There were some records of referrals and communication. However, staff were not always keeping up to date records. We could not be assured people's medicines were being reviewed regularly.

The failure to take appropriate actions to ensure medicines are managed in a safe way is a continued breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Learning lessons when things go wrong
● Systems were in place to monitor accidents, incidents near misses and to learn lessons. Staff told us they were told about accidents and incidents that had occurred on the previous shift at the handover meeting. However, incidents and accidents were not always formally discussed as a staff team, so those not working or present on the day of the incident were not aware about people at risk and how to support them accordingly. Accident records evidenced two moving and handling incidents had occurred, one which caused an injury to a person and one that had potential to injure a person. The staff involved in the incidents had received updated moving and handling training. The provider had not taken an opportunity to discuss lessons learnt and safe moving and handling practice at a staff meeting which took place 14 days after the second accident. This is an area for improvement.
● The registered manager regularly audited and reviewed any accident and incidents.

Preventing and controlling infection

At our last inspection, we were not assured that the provider was promoting safety through the layout and

hygiene practices of the premises. We were not assured that the provider was preventing transmission of infection and/or managing outbreaks through staff training, practices and deployment. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12 in relation to infection control.

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was supporting people living at the service to minimise the spread of infection.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was responding effectively to risks and signs of infection.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
People received visits from relatives and friends when they wished. Relatives and friends visited people during the inspection.

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 our last inspection of Effective in October 2019 we rated this key question good. At this inspection the rating has changed to requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was not working within the principles of the MCA, appropriate legal authorisations were in place to deprive a person of their liberty. Registered persons did not have full oversight of DoLS. Registered persons monitored when DoLS were due to expire and when DoLS applications were required. However, they did not have a record of what conditions were in place for people that had conditions on their DoLS. Any conditions related to DoLS authorisations were being met.
● People's care plans contained conflicting and confusing information about their mental capacity. Mental capacity assessments had been undertaken; however, they were not always clear about what the decision being assessed was. It was not clear when a person lacked capacity, and when a best interest's decision had been made, who had been involved in the decision-making process.
● Where people had a DoLS authorisation, this was not detailed in their care plans. This meant staff did not have the information they needed to understand people's legal status and make sure their rights were upheld. Staff were unable to seek advice from the management team in relation to DoLS because the management team were unaware of who had DoLS conditions in place.

The failure to ensure people's rights were upheld within the basic principles of the Mental Capacity Act 2005 is a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People had not always been supported with accessing GP and healthcare specialists in a timely manner when required. One person's records showed nursing staff had waited 14 days to contact the GP when the person was severely constipated.

● Most people had access to health services when they needed it. However, outcomes of appointments and details of concerns were not always recorded and clear. For example, where dieticians and tissue viability nurses had assessed people following changes in health, these had not been documented and shared with all staff. This had led to one person not receiving an extra dose of prescribed fortified drink to help them increase their weight and gain essential nutrients.
● Information about people's declining health and outcomes of appointments had not always been shared with the staff team in handover meetings. This meant staff did not always have the most up to date information to support people effectively.

The provider had failed to provide care and treatment to meet people's assessed needs. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● Records evidenced that staff had called 999 and 111 when required to meet emergency medical needs. The GP carried out a weekly video call with the service.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Prior to people moving into the service their needs were assessed. These assessments were used to develop the person's care plans and make the decisions about the staffing hours and skills needed to support the person.
● The assessment included making sure that support was planned for people's diversity needs, such as their religion, culture and their abilities. People were reassessed as their needs changed to ensure the care they received met their needs.
●The provider used nationally recognised assessment tools to identify and review people's needs such as Malnutrition Universal Screening Tools (MUST) and pressure sore risk assessment screening tools (Waterlow) to calculate people's pressure risk.
● Oral Health Care for Adults in Care Homes best practice had been implemented. People's oral health care needs were routinely assessed. Care plans provided information in relation to people's needs in this area. Most staff had completed training in supporting people with their oral care.

Staff support: induction, training, skills and experience
● Staff had received training to enable them to meet most people's specific health needs. The provider had a system in place to ensure staff completed training in autism and learning disability, many staff had already completed this training. However, some care staff had not undertaken training around catheter care despite providing care for people with catheters in place. This meant they may not have all the information they needed to provide person centred care. Some staff we spoke with said they had not had catheter care training despite working with people with catheters. One staff member said, "I have not done catheter care training, I tend to work with staff that have done the training, I would report concerns with urine to the nurse." This is an area for improvement.
● Records showed that some staff had not had fire drills within the last 12 months. One staff member said, "I have not recently had fire evacuation training, I don't feel confident in using it [fire evacuation equipment]." Another staff member said, "We do a fire test on a Monday, we had training in someone's room to practice the evacuation sheet, I have not had a fire drill." This is an area for improvement.
● Nurses and care staff had received statutory mandatory training, infection prevention and control, first aid and moving and handling people. Staff received effective support and supervision for them to carry out their roles. Staff were supported to undertake qualifications in relation to their roles. Staff told us they felt well supported by the registered manager.
● Systems and procedures were in place to provide support to nursing staff to maintain their skills and Nursing and Midwifery Council (NMC) registration as part of the revalidation process. Systems were in place

to support the nursing staff achieve revalidation. Specialised training courses were available to nursing staff to enable them to learn or refresh nursing tasks, such as vaccination and wound care.

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

● People told us they liked the food at the service. People told us, "The food is good" and "The salads are lovely". We observed mealtimes to be relaxed and people were offered choices of meals and offered more if they wanted it.

● Meals and drinks were prepared to meet people's preferences and dietary needs. These included pureed meals and low sugar diets.

● People had their meals in the dining room and in their bedrooms. The menu board in the dining area listed the choices available. Staff told us they helped people to make their meal choices if they needed it.

● There was a system in place to check that people had drunk enough to keep themselves healthy and hydrated. Records relating to food and fluid intake were clear and consistent. However, the nurses and management had no oversight as to whether people had drunk enough to maintain good health, because the records were not routinely checked. This is an area for improvement.

● People had been weighed regularly. Where people had lost weight and this was a concern, appropriate referrals had been made to the GP and other healthcare professionals.

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

● The design and layout of the service met people's needs. Signposts were in place which helped people living with dementia. People knew where their rooms were and where to find communal areas such as the lounge, dining room, bathrooms and toilets.

● People's rooms had been furnished with items to suit their individual needs, people had pictures, photographs and trinkets as well as personal items to ensure their rooms were personalised to their own tastes. Married couples were enabled to stay together in a larger shared room.

● People had access to a small paved courtyard which was secure and could be accessed at any time.

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

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

At our last inspection, the provider failed to have effective systems in place to asses, monitor and improve the quality and safety of the service and failed to ensure that records were accurate and complete. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had also failed to notify CQC of incidents. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 17.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

● At the last inspection, the systems to review and check the quality of the service were not always robust and timely action had not always taken place to address issues found. We served the provider conditions on their registration which required them to effectively assess the quality of the service. The provider sent CQC monthly reports of their monitoring. However, at this inspection we found that the systems in place to audit the quality of the service continued not to be robust or sufficient to alert the provider of concerns and issues within the service. Audits had not picked up shortfalls in practices in relation to risk assessment, fire safety, medicines management, staff deployment, mental capacity and DoLS and safeguarding.
● At the last inspection we raised that there was a lack of management oversight and management action at the service because the registered manager had spent more than half of their time working as a registered nurse as part of the care team. At this inspection, the registered manager was only on shift as a nurse once a week. When the registered manager was away from the service, there were qualified nurses on shift to take action. However, action had not always been taken and systems to monitor the service had not always been carried out by staff with lead responsibilities. For example, daily records had not been reviewed regularly to ensure people were safe (such as drinking enough to stay well, opening their bowels regularly and having their care to meet their assessed needs.)
● At the last inspection, some staff told us there was a poor culture within the service and made allegations of bullying within the staff team. At this inspection, some staff we spoke with reported that this was still a concern. They explained new staff experienced bullying, intimidation and unfavourable treatment from

some experienced staff. They informed these staff members only acted in this way to staff, they treated people living at the service with dignity and respect. Staff were concerned that some staff may leave the service as a result of the issues, which would cause issues because of the national staffing crisis. We again reported this to the registered manager and nominated individual to address. Action taken following the last inspection to address this had not been successful.

● At the last inspection, records were an area of concern. Records were not always complete or accurate. At this inspection, records remained an area of concern. It was not clear whether people had had their bowels open, contact with GPs and healthcare specialists had not always been recorded in people's care records (and then updated in care plans, risk assessments and wound charts).

● The provider had a system in place to review each person's care plans, risk assessments and care and treatment on a monthly basis. This was called resident of the day. This system to carry out a review was not robust. For example, care plans and risk assessments had been reviewed monthly and essential information had been missed. One person had been assessed by a dietician as requiring a change of prescription on 24 October 2022. The resident of the day review was carried out on 01 November 2022 and the changes had not been updated in the care plan or risk assessments and the information had not been shared with other people who needed to know. This had led to a dispute/query being raised with the pharmacy when the new prescription had been delivered.

● People were asked for feedback about their care and support. The provider had sent out surveys to people in June 2022 to gain feedback about the service. The survey results had been collated, the feedback showed that people had not always felt listened to. Some people raised in the surveys that they were not entirely happy with staffing. The provider had not provided feedback to people about the outcome of the surveys and what they planned to do to address the feedback received. The registered manager told us they planned to do this at a future residents meeting. A residents meeting had been held in September 2022 and it had not been discussed.

Registered persons have failed to have effective systems in place to asses, monitor and improve the quality and safety of the service and failed to ensure that records were accurate and complete. This is a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● At the last inspection, registered persons had not always notified us of specific incidents relating to the service in a timely manner. These notifications tell us about any important events that had happened in the service. At this inspection we found, CQC had been notified of a serious injuries, abuse and deaths. However, CQC had not been notified of any DoLS applications or authorisations, despite the registered managers records showing there had been 12 applications, 10 of which had been authorised.

The failure to notify CQC of DoLS authorisations and applications is a continued breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

● It is a legal requirement that the latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. The last inspection rating was prominently displayed at the main entrance.

● There continued to be a range of policies and procedures available to staff governing how the service needed to be run. These were regularly reviewed and updated.

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

● People gave us feedback about resident's meetings. They told us, "They have meetings. I don't go. Sitting

in a chair for a long time is uncomfortable"; "I have been to one"; "No, residents' meetings" and "Once, since I have been here."

● The provider engaged with staff and involved them. Staff told us they were able to share their ideas. Some staff told us staff meetings had taken place regularly, other staff said they didn't happen very often, if at all. We reported to the provider that there was inconsistent practice in relation to this across the staff team.

● Staff gave us mixed feedback about communication, the culture and the feeling of the service. Comments included, "I do feel well supported, [registered manager] is very good, I can chat about anything and I can discuss with the nurses too"; "There are no staff meetings as of late. No handover sometimes when coming on shift in the afternoons which is poor. We do get messages through WhatsApp"; "If there was a problem, I feel I can approach [registered manager] or the nurses or [nominated individual]" and "Both the registered manager and [nominated individual] are very approachable. I'm quite happy."

Working in partnership with others

● Staff told us they were kept informed about engagement and outcomes with health and social care professionals that could result in a change to a person's care, for example, following a visit from the community nurse, GP or dietician. Staff told us information was shared in handover meetings and through group chat.

● The registered manager continued to engage with external support networks. The registered manager had also worked closely with other registered managers in the provider's other services.

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

● Compliments had been received. These included, 'Thank you for all that you did for [person] may she now RIP' and 'Thank you for being there to get [person] on zoom it is much appreciated by us all. We know time is limited for you.'

● Relatives and visitors gave us mixed feedback about communication. Comments included, "I came to a relatives meeting a while a go"; "I get the sense that when I engage with them, they are organised. I don't think they trigger the communication; it is always in response to me communicating with them" and "The majority of the time they carry out what is suggested. The last meeting someone mentioned about the number of staff. They said not enough to cover. They got a few more people, agency staff."

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 provider and management team understood their responsibilities under the duty of candour. They apologised to people, and those important to them, when things went wrong.

● Staff gave honest information and suitable support, and applied duty of candour where appropriate.

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 18 Registration Regulations 2009 Notifications of other incidents Registered persons had failed to notify CQC in a timely manner about DoLS applications and authorisations that had been made. Regulation 18 (1)(4) of the Care Quality Commission (Registration) Regulations 2009.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to provide care and treatment to meet people's assessed needs. Regulation 9 (1)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure people's rights were upheld within the basic principles of the Mental Capacity Act 2005. Regulation 11 (1)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Registered persons had failed to ensure risks were robustly identified and managed to prevent harm so people received safe care. Registered persons had failed to take appropriate actions to ensure medicines are

managed in a safe way.
Regulation 12 (1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Registered persons had failed to protect people from abuse and improper treatment. Regulation 13 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Registered persons have failed to have effective systems in place to asses, monitor and improve the quality and safety of the service and failed to ensure that records were accurate and complete. Regulation 17 (1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure sufficient, skilled staff are deployed to keep people safe. Regulation 18 (1)