Norfolk Care Homes Ltd

Iceni House

Inspection report

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Date of inspection visit:
27 November 2019

Date of publication:
17 July 2020

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Iceni House is a residential care home providing personal and nursing care to 62 people aged 65 and over at the time of the inspection. The service can support up to 75 people over two floors. The units accommodate people requiring residential or specialist dementia care.

People's experience of using this service and what we found
People were not receiving a safe service and could not be assured that management would address their concerns. The service had poor oversight of risk and was ineffective in taking necessary actions to address shortfalls in the service. Medicines had not always been well managed, and we were not assured people always got their medicines as needed. Environmental risks had not been identified.

Record keeping was very poor and data was not collated to determine where the risks were, and action plans were not developed in a timely way to help mitigate risks.

People's routines were determined by staffing levels rather than their own needs and preferences. Staff did not always have time to provide person centred care in line with people's preferences.

Staff recruitment processes were in place but not sufficiently robust and although staff training, and staff supervision was in place there was limited evidence of how staff influenced the service. Training was not firmly embedded, and we could not see how training informed good care.

People did not always have their health care needs met and there was poor follow up. People were not supported to eat and drink in line with their preferences and records were not completed contemporaneously so we were not assured of their accuracy. Care plans and daily notes were poorly written, out of date and not sufficiently personalised.

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 did not support this practice.

People did not have choice in their care and routines because staff did not have sufficient understanding of their needs or communicate with people effectively.

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

The last rating for this service was good (published 18 December 2017).

Why we inspected
The inspection was prompted in part due to concerns received about Iceni House. We were made aware of

specific safeguarding concerns. The local authority quality monitoring team visited on 21 and 28 October 2019 and completed a review of the service and rated it poor. We carried out our inspection on 27 November 2019 because despite regular involvement from the Local Authority safeguarding team and quality team the service was failing to make enough improvement to ensure the health and safety of people using the service.

Enforcement
We have identified breaches in relation to the way people's risks are monitored and mitigated, medicines management, staffing, reporting incidents, consent and governance systems at this inspection. 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 to discuss how they will make changes to ensure they improve the support people receive. We will work with the local authority to monitor progress.

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

Iceni House

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by two inspectors, an assistant inspector, a pharmacy 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
Iceni House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
Before the inspection we reviewed all the information we already held about the service including recent feedback from the Local Authority, complaints, share your experiences, safeguarding notifications and incidents. We took this into account when we inspected the service and made the judgements in this report.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection
We carried out observations across the day on both floors, across all areas. We spoke with four people, one visitor and nine staff members, some of who were seniors and team leaders. We also spoke with three agency staff. We spoke with the activity staff, the cook, the domestic, the housekeeper the registered manager, and the director. We met and spoke with the visiting pharmacist and a member of the local authority quality team and safeguarding team but only to confirm the purpose of their visit.

After the inspection
We formally wrote to the provider asking them how they were going to mitigate immediate risks and assure us they had enough staff on duty and sufficient management over the forthcoming weekend and following week. We received some assurances and their current action plan and oversight of risk. We contacted the local authority, so we could be assured of their actions.

Inadequate

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management

- The service was not effectively managed in line with people's needs and there was insufficient oversight of risk.
- This is a large home and we observed people sitting unoccupied and unsupervised with no means of summoning assistance should they need to. It was difficult to find staff and often only agency staff were visible, and they were providing one to one care.
- The nature of people's illness and disability meant some people were distressed or could hit out when feeling unsettled. There had been a high number of altercations between some people. There was a lack of clear strategy on how to manage people's distress behaviours.
- Some people had a history of poor mental health, possible self- harm and, or trauma but nothing was documented in regard to how risks were managed.
- Staff received training in dementia care, but staff could not tell us how they implemented this in the workplace or how this ensured they could adequately meet people's needs.
- Staff did not seem mindful of how poor organisation and communication affected people's experience of the service. For example, some people were left in bed for hours which could increase their risk of developing pressure ulcers..
- At lunch time people were sat at an unlaid table long before the meal was brought in. Some people became visibly agitated and started arguing with others sat at the same table. Staff were unaware of minor conflicts and communication between staff and people using the service was poor.
- Staff gave people information verbally but did not check that the person was able to understand and process the information. This increased people's frustration.
- The service employed a maintenance person who had a good oversight of routine maintenance and servicing and they kept the records up to date.
- We did however identify some risks at the service which had not been identified by the service.
- Radiators upstairs in communal areas and bedrooms were not covered and we identified overloading of individual electrical sockets and items placed precariously near edges such as a cardboard box on a wardrobe and kettle and trailing wires near the edge of a work surface.
- Doors were left unlocked to the plant room; the hairdresser's room and the linen cupboard was unlocked leaving access to fuse board and other electrical sockets.
- Care plans and risks assessments were not fully up to date and where a need or risk had been identified there was not a clear plan in place to address the level of need and risk. For example, some people were being weighed weekly. This information was not included on the handover sheet for staff. Some people were not on weekly weights and had recent unintentional weight loss.

Using medicines safely

● The service had recently changed to an electronic medicines system which staff had received training for and were being supported by the clinical commissioning pharmacy team. Prior to the introduction of this system there had been some medication errors which had been poorly investigated and some of the paperwork requested at the time of the inspection could not be found, for example the incident record pertaining to the incident.

● We were not confident in the systems and processes governing the safe administration of medicines because we identified some basic principles were not being adhered to.

●We found irregularities in stock control, which meant people had not always receiving their prescribed medicines.

●Guidance was not in place for everyone who took medicines when needed which meant staff might not be aware when to administer certain medicines.

● We found inconsistencies in recording of fridge temperatures which are necessary to ensure medicines are stored at correct temperatures to preserve their shelf life and effectiveness.

● We identified poor management of creams which were not stored safely or dated when opened.

The above evidence demonstrates people's risks were not consistently mitigated to protect them from the risk of harm and medicines were not managed safely. This was a breach of Regulation 12 (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

●Observations gave us concern about staffing levels, one person told us, "I do seem to sit around a lot – I'm not supposed to walk but if they don't answer the bell then what choice do I have? " We asked them if there was any impact on them having to wait and they told us, "I'm ashamed to say I have wet myself several times because the pads leak badly."

● The service had a dependency tool for each person, but these did not have robust information and were out of date. Staff told us staffing had been reduced recently because the numbers of people using the service had reduced. This meant staffing levels were not based on people's specific needs.

●The director had agreed with the local authority not to take any new admissions until they were able to make the necessary improvements. As a result of reduced numbers of people living at the service the director had also reduced the staffing levels. We asked the director to review this immediately. They informed us they had re-instated staff.

● The service relied on agency staff to provide some of their hours and although they had achieved some consistency of staff we observed poor team work. Agency staff were not always involved in shift handover and did not have the information they needed about people being supported.

●Staffing was fragmented with staff being pulled off the floor to support other parts of the home. There was no clear analysis of when additional staff might be needed to help ensure people's needs were met in a safe, timely way. For example, in the morning when people needed support with personal care or at meal times.

●Some people were not up until lunch time because staff had not had time to get people up, lunch was late, and a lot of people did not have opportunities to join in planned morning activities as they were not up in time or were left in their room.

● Recruitment processes were not sufficiently robust. We identified staff working on the floor who had additional support needs, but this had not been documented in terms of the support they could expect.

●Pre employment checks were carried out to help ensure staff were of good character and had not committed offences which might make them unsuitable to work in care.

The provider had not ensured there were enough staff available who were deployed effectively to provide direct care to people who used the service. This was a breach of Regulation 18 of the Health and Social Care

Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● People did not always experience a safe service. During our inspection we saw accidents and incidents were not appropriately recorded and investigated. For example, we found one person had injuries recorded on a body map but there was no corresponding accident/incident record. This meant that the cause of the accident/incident was not fully investigated

●Risk management plans were poor as information was generic and not around the persons specific need or level of risk.

●The service was not effectively investigating or monitoring safeguarding incidents. The outcome of safeguarding investigations or how the service was preventing further incidents was not recorded. We saw a number of incidents relating to the same people which the service had not recognised. This put people at risk of repeated incidents.

●Staff received training to help them recognise abuse and recognise what actions they should take however poor recording and reporting meant they were not putting this into practise.

Preventing and controlling infection

●The service was cleaned to a reasonable standard and there was sufficient organisation of the domestic staff and oversight of cleanliness from the housekeeper.

Learning lessons when things go wrong

● The service did not learn from one incident. There was poor recording and analysis of data. Where actions were identified following an incident these were not always carried forward or shared with staff.

●This meant change in practice were not instigated following significant incidents or patterns identified as part of the analysis of data.

Inadequate

Is the service effective?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

●People were poorly supported to eat and drink in line with their preferences and needs.

●We observed the lunch time experience and found it to be chaotic on both floors. The tables were not set until immediately before lunch service, there was insufficient clean cutlery and staff started moving around tables and chairs.

●People were not given choices in relation to their dietary preferences in a way which was meaningful to them. This would have supported people living with dementia to make a choice.

●Food was served from a hot trolley outside the dining area. Staff asked people do you want A or B. They were not shown two different plated options, so they could see the food. Some people did not understand what food they were about to be served and when they did not like the option an alternative was not sought.

●One person told us they were not asked how much they wanted on their plate, they said this was just served up by staff. This meant the person was not given a choice at the time of the meal being served up. We did not observe people being offered seconds or a hot drink after their meal.

●Kitchen staff were keen to tell us of the improvements they had made recently to the kitchen, including improved cleanliness, changes to the menu and improvements in record keeping. They were familiar with people's dietary needs and preferences. We found however care staff were not and they were taking food to people. At least one person got a meal which was not in line with their preferences. We observed another person spitting out their food as they clearly did not like it.

●Staff were not aware of risks in relation to people's dietary needs or if anyone had a modified diet due to the risks associated with dysphasia and choking. People in their room and people in the dining room got minimal supervision. Prior to the inspection a visiting health care professional told us they had observed a person been fed whilst lying in bed. We did not observe any immediate risk, but we were concerned that staff did not know what the risks might be'.

●Some people needed a special diet to help promote their health. Records demonstrated this was not being adhered to and for one person there was an ongoing safeguarding concern.

●Staff were not clear as to who was at risk of unintentional weight loss. Team leaders and managers had an overview but were not observed directly supporting care staff. A weight priority list had just been implemented with a number of people put on weekly weights. This had only just been implemented as a result of concerns raised by the local authority. This meant the home had not had effective systems prior to this to establish risks of malnutrition.

●We reviewed a number of people who were not weighed weekly who had recent weight loss. There was no evidence of timely actions to address this. Staff told us everyone was on a fortified diet rather than having an

individual approach to people's dietary needs.
●Food and fluid charts had recently been introduced for everyone to establish a baseline of how much everyone was eating and drinking. We were not assured as to their accuracy and value as records were not made contemporaneously and did not match our observations.

The provider had not ensured that they were meeting people's hydration and nutritional needs. This was a breach of regulation 14 of Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorizations to deprive a person of their liberty had the appropriate legal authority and were being met.
● The service had not always applied for DoLs when necessary or in a timely way. Once authorised the service had not kept these under review or reapplied for them when they had expired.
●Decision making was poorly documented with some conflicting information or no information at all. Where DoLs had been applied for we could not see the corresponding assessments.
●Record keeping was poor particularly around individual decisions where people lacked capacity. Records simply said lack capacity and staff had not considered each decision and situation by its own merit. This was not in accordance with the MCA.
●Staff had received training to help them understand the Mental Capacity Act 2005 and knew to assume people to have capacity unless proven otherwise. Staff training had recently been updated because of the concerns identified by the local authority about records and staff's knowledge in this area.
●Despite recent training we observed staff still making decisions on people's behalf and communicating with people in a way that was not effective. For example, staff offered choices verbally. One person was known to always say yes so when offering a choice between a or b they were not able to communicate their preference. Staff knew this but did not help the person communicate their needs in a way suitable for them.
● Best interest decisions were not recorded for key decisions such as the flu jab, when people had been deemed as lacking capacity to decide whether to have treatment or not. Records did not make it clear who should be involved in the decision-making process and which relative or other had power of attorney for health, welfare and, or finance.

The provider had not ensured that they were meeting people's needs in relation to mental capacity, DoLs and consent. This was a breach of regulation 11 of Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Staff working with other agencies to provide consistent, effective, timely care
● The service had not worked effectively with other agencies or advised them of the difficulties they were facing with some individuals. Behaviours were poorly managed and referrals to mental health services not followed up.
●The service had not reported all now known incidents through to the local authority safeguarding team or

the CQC and the collation and analysis of information about them was poor.
●The standard of documentation was generally poor, contradictory, not cross referenced and it was not possible to see if the service followed up referrals in a timely way or had an accurate picture of need or risk.

Adapting service, design, decoration to meet people's needs
● The design of the building did not fully lend itself to people's needs. The home was spacious and there were lots of different rooms people could sit in. We found however for some rooms, they were uninviting, and lights were off which acted as a barrier.
●Dependency tool did not take into account the environment when planning for numbers of staff. .
● Doors were not personalised which meant people with dementia might have difficulty recognising their room and signage was not good.
● People were not easily able to leave the home should they wish to; a recent incident had meant doors were now alarmed.
●We identified risk to people's safety including doors that should have been locked for people's safety unlocked and chemicals harmful if consumed left out.
●The service was generally in a good state of repair, but some areas needed refurbishment and showing signs of wear and tear.

Supporting people to live healthier lives, access healthcare services and support
● People did not always get their health care needs met because there was unclear guidance, poor identification of risk and a lack of recording in terms of follow up action. For example, where a person had been referred to a GP or nurse you could not see what advice they had given or how this was incorporated into the persons care.
●Staff were not mindful of people's behaviours and communication needs and there was poor documentation around mental health and risks factors associated with people's environment.
●Where guidance was in place it was not clear if staff adhered to this and a number of safeguards have been raised by the local authority.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were poorly assessed prior to admission to the home. This meant we could not be assured how the service was confident they could meet the persons needs prior to their admission. The assessment tools used to assess people's needs were not used effectively or in line with the guidance
●On admission there was some evidence that the staff could not meet people's needs or keep them safe. For example, as people required more supervision the service had not recorded or evaluated a change in their need or ensured they could resource their needs adequately.

Staff support: induction, training, skills and experience
●Staff told us they got the training they needed through their induction and additional training in line with people's needs. They told us however they did not have support to reflect on issues in the home or identify further training which might support them. Training and supervision were largely up to date.
●Staff spoken with either had previous experience or had completed additional qualifications in care. Where staff were new to the home or new to their role, and we could not see that their training was firmly embedded or that staff had clear areas of oversight and responsibility. Care staff told us they would refer to a team leader, but team leaders were not observed to be on the floor as much as were completing paperwork so were not leading by example or monitoring the care being delivered.
●Some staff told us that the training relied on workbooks and they could not ask questions or share their learning with others. They had limited opportunity for reflective practice and staff practice was not observed regularly.

● Some staff said some of the agency staff had poor English both spoken and written. We spoke with several agency staff who communicated very well but one agency spoke in a raised voice when speaking with people.

Requires Improvement

Is the service caring?

Our findings

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

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

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

- The care we observed was functional and the service was not established around people's individual needs and preferences. It was task focused as we found at times care and communication was rushed and people's choices and control over their care was diminished.
- Records were poor and did not look at risk factors or people's needs in relation to their human rights, religious or cultural needs. A life story and one-page profile contained minimal information and was not sufficiently meaningful. There was some detail, but it was not possible to see how this information was acquired or its relevance.
- One person's records reviewed had a 'sexuality' care plan in place, it just referred to their clothing and for staff to ensure they were dressed appropriately. This was not put into any context and we did not know how this person liked to dress or what assistance they needed. There was no reference to relationships, other than family or their sexual orientation, culture, or background.

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

- Care plans were poor as was the general record keeping. These were being updated onto standardised paperwork which had been improved. Staff told us they consulted people using the service but there was no recent evidence of this.
- Consent had not been established in some people's individual records we looked at neither had permissions been sought to share information. People's preferred communication method was not recorded.
- The registered manager confirmed family meetings and resident meeting were not currently well established but there was some evidence of how the service took into account the views and experiences of people using the service.
- There was nothing around the home to indicate what was happening, activity schedules had not been put up but were ready. There was nothing to orientate people to the day and time.
- Surveys went out to staff, people using the service, visitors and health care professionals twice a year. and there was a monthly audit which took into account people's experiences of the service.

Respecting and promoting people's privacy, dignity and independence

- Peoples' independence was not promoted.One person told us," I generally have my meals in bed but do sometimes want to get up and socialise with others in the dining room, I wish staff didn't just assume that I want to eat here, that they'd ask me what I wanted. The food is not bad, but I'd like to be able to say how much was put on my plate – it generally just arrives on a covered plate."

● Everyone had plastic cups and the service did not recognise people's individual needs or preferences.

●Condiments were not put on the table and nobody had plate guards, built up cutlery or slip mats which might have helped some people maintain their independence and dignity. We reached this judgement because people were observed struggling to eat and chasing food around their plate.

● Routines were not determined by people using the service. People told us they had to wait for staff to assist and response times to call bells could be slow.

●Some people did not have a call bell to hand and we were not clear if people had sufficient understanding and cognition to use a call bell

●Some people were still in bed just prior to lunch, it was not clear that this was their choice, staff told us that's how long it took them to get people up. Some people told us they liked to get up early and had to sit and wait.

●There was limited opportunity for people to help themselves to a drink or a snack.

●Activities of daily living were not clearly linked to people's preferences and routines.

● People told us staff were kind and chatted to them throughout the day. We observed some good interaction but also observed staff did not have time to provide meaningful interactions other than those based on tasks because of the staffing levels

Requires Improvement

Is the service responsive?

Our findings

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

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

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

● We were unable to establish if people's needs were met in line with their preferences. Staff were rushed, some people spent a disproportionate amount of time in bed and routines were not clearly established.

●Some people who needed minimal support told us they were happy with the support they got but they were more independent and able to ask. Most people would require staff to anticipate their needs and staffing levels did not allow this.

●Lunch was late and there was not much of a gap between lunch and tea which meant meals were not spaced out adequately and might mean people would not be hungry due to the spacing of the meals.

● There was minimal staff engagement and when staff did talk to people they did not give people time to process information. Communication was around tasks rather than people's wellbeing.

●Daily notes for people gave us minimal information and did not relate to what care was provided or how people had been in themselves that day. There was a list showing if people had received personal care etc, but this was a tick list and did not give person centred information.

●Care plans were did not contain sufficient detail as to how people liked to receive their personal care. They were not in place for every identified need or kept up to date.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● Activities were provided but observations of these were they were limited to small groups and we only saw the activities coordinator engaging with those nearest whilst other people were disengaged.

On the day of inspection, we saw limited activity as activity staff were supporting care staff with care, handing out meals and drinks before doing an activity with a few people. Pictures were cut out from old newspapers. One person told us "I don't do the activities I'm not a two-year-old, so I don't want to do 'colouring in." They told us about their previous profession and interests but then said, "There's nothing like that here."

●Staff did not consult with people before putting music on and the televisions were on constantly. We could not see how activities agreed tied into people's specific interests and preferences. For example, we saw one person alone and distressed. Their care plan stated they needed to be kept sufficiently occupied as their previous employment had involved a lot of activity. Their records did not indicate how staff were meeting their needs.

The provider did not keep accurate, up to date records so we could not be assured people received the care they needed. in relation to their health, care and welfare. This was a breach of regulation 9 of Health and

Social Care Act 2008 (Regulated Activities) Regulation 2014.

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

- Care plans gave limited information and did not explore the impact of cognitive impairment and sensory impairment on people in relation to communication and interaction.
- Some staff demonstrated good interpersonal skills, but this was variable. Some staff were described as having poor language skills and unable to complete records. Other staff simply did not have time to talk to people and take time to understand their needs.

Improving care quality in response to complaints or concerns

- The service had a complaints procedure, and complaints were responded to and reviewed as part of the quality assurance process. Compliments were seen and collated by the service to demonstrate what they were doing well.

End of life care and support

- Where end of life care plans were in place these contained a lack of specific detail and were not sufficiently person centred. For example, where a person had a known religion it did not state any specific cultural or religious observations.
- Staff received training and support in providing end of life care.

Inadequate

Is the service well-led?

Our findings

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

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Since the last inspection standards have not been maintained at this service and the service is no longer rated as good. Systems and processes were ineffective.
- Changes in staffing had impacted on the service. Both unit managers had left and there was a high number of agency staff which impacted on the care and stability of the service.
- The director employed a quality assurance person to oversee audits monitoring safety and quality, this was not effective .
- People's records were poor, so we could not establish if people were getting the care they needed. Pre-admission records, daily notes and care plans failed to adequately record changing needs or risk factors. The lack of proactivity meant some people continued to be at risk from falls.
- Risk management was poor. For example, incidents between people were high. They were poorly recorded, and the manager and director did not use the information to plan the service. For example, they did not review times of incidents to see if staffing might be a factor. They did not explore why incident numbers were so much higher some months than others.
- The falls management policy said about referring a person to the falls team after three falls. This did not always happen and was not followed up which meant people continued to be exposed to unnecessary risk. The service did not take into account the severity of the falls.
- Corresponding body maps and monitoring records were not always in place. Risk assessments and care plans were not always updated when the accident record said they had been. Some care plans had not been reviewed since September and had not included recent falls or bruising.
- We were unable to identify how the director and manager had oversight of people's care. It was the local authority not the provider who had put in place a risk register identifying those at highest risk. The registered manager was not able to tell us how the local authority had identified people at highest risk.
- We asked for a copy of the risk register and it did not include everyone. Dependency tools were not up to date and other than the daily handover sheet there was nothing to indicate the level of risk for each person or if the risk had changed.
- We case tracked people not on the high-risk list and found factors which would make them vulnerable. For example, they were at high risk of falls nutritionally compromised and susceptible to pressure damage. Some care records were not up to date which meant we could not be sure of the level of risk.
- Staff handovers were not effective in ensuring staff were aware of people's needs. This was because staff had differential shift patterns and handover tended to take place between team leaders and was written. Care staff had information passed to them verbally and agency staff relied on the records in people's rooms.

●If a staff member had been off for several days which was common because of the shift pattern they did not have the up to date information they needed. Staff tended to swap floors as well sometimes during the day so did not have the most up to date information about people's needs.
•Daily catch up meetings were not held between the heads off departments to help ensure effective communication and to focus of any risks emerging across the day. Since the inspection the director has confirmed this is in place.

The provider had failed to ensure there were effective systems in place to monitor the service and mitigate risks to people. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● Notifications and safeguarding concerns had not always been raised as appropriate or investigated fully.
● Duty of candour and lessons learnt were not clearly established within the service.
●Actions plans had been developed on the back of concerns identified by the local authority and not the service themselves.

The provider had failed to ensure that the safeguarding team and Care Quality Commissions were informed of incidents, accidents and notifications in a timely way. This was a breach of Regulation 18: Notifications of other incidents Care Quality Commission (Registration) Regulations 2009: Regulation 18

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
●There was limited evidence to support the fact that people managed their own care and had input into how they wanted their care to be provided. People were not given regular opportunity to discuss their individual care needs or wider issues in the home.
●Preadmission assessments did not identify people's wishes, preferences and reasons for needing care.
●Peoples care objectives were not identified and care plans were not person centred and care was task focused.
●There was limited opportunity for people to influence their care or raise suggestions as to how it could be improved upon.

Continuous learning and improving care
●The service has had a history of non- compliance.
● The registered managers office was not situated in the heart of the home, so they could not see what was going on. They were insufficiently supported by the provider, as key staffing vacancies had not been filled and the impact of these vacancies had not been considered in terms of workload.
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Working in partnership with others
●Safeguarding referrals had been raised by the Local Authority rather than the service.
●Referrals to other health care services had been made but records were so poor it was difficult to see if referrals were timely or had been chased up.
●There was poor engagement from the service to relatives, friends and family.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
●The service did not achieve good outcomes for people because care was task focussed rather than person

centred.

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 The provider did not always notify CQC of incidents in a timely way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care plan and other associated records did not tell us what people's needs were or how care should be planned around them to ensure people received safe, effective care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The service had failed to take into account people's specific wishes or gain their consent for care and treatment. Mental capacity assessments were not decision specific and the service had not asked the local authority to review DoLS granted within the relevant timeframe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service had failed to sufficiently protect people because they did not have a robust incidence recording system in which incidents

were reviewed and adequate measures were put in place to reduce the likelihood of a further incident.

Care plans were not up to date and where a risk had been identified a risk management plan was not put into place.

Some immediate risks associated with the environment had not been identified by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was insufficient oversight of risk and the service was not managed in the best interest of people's health and welfare.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured there were always enough staff to meet the assessed and changing needs of people using the service.