Noblefield Limited

St Clements Nursing Home

Inspection report

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Date of inspection visit:
17 December 2018

Date of publication:
19 September 2019

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 17 December 2018 and was unannounced. We last inspected this service on 30 March 2017 and rated the service 'Requires Improvement' overall and in each of the five key questions. At our earlier inspection in July 2016, we had identified that the provider was in breach of seven regulations and people received poor and unsafe care. Following this inspection, we placed the provider into special measures. Our last inspection in March 2017 found the provider had met those previous breaches and was no longer in special measures. The provider had made some improvements to move from an 'Inadequate' overall rating, to a 'Requires Improvement' overall rating.

However, at this inspection on 17 December 2018, we found the provider had failed to sustain and build on improvements and the service had deteriorated. The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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."

We found the provider had breached four regulations of the Health and Social Care Act 2008 which relate to good governance, safe care and treatment, dignity and respect, and person-centred care. We found the provider had also failed to inform the Commission of specific events and incidents as required by law. We will report on action we have taken when it is completed at the back of the report.

St Clements Nursing Home is a care home which provides nursing and personal care for up to 37 older people. 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 home has accommodation over two floors with a passenger lift to facilitate access. There were 23 people living at the home at the time of our inspection.

There was a new manager at the home who had joined in November 2018 and had submitted their application to register with the Commission. The manager was present during our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We identified a breach of the regulations because people's risks were not all safely managed, including poor support some people received with their medicines and bedrail use which placed them at risk of harm. Although people and relatives told us they felt safe, systems were not robust to ensure people could always be safeguarded from the risk of abuse. There were not always enough staff to meet people's needs.

Communal areas of the home were kept clean by domestic staff although we detected odours and infection control concerns in some areas of the home. Systems did not ensure the consistent safety of the premises.

People's needs were not always understood and effectively responded to by staff. Staff had not received the training and guidance required for their roles and improvements were still required to how people were supported with their meals. The design and décor of the home were not always developed around people's needs. People were supported to make their own choices and decisions.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People's risks were not all managed safely, including with bedrail use and medicines support, and this put some people at risk of harm.

There were not always enough staff to safely meet people's needs.

People told us they felt safe using the service, however systems were not robust to ensure people could always be safeguarded from abuse.

Improvements had been made to the provider's recruitment processes to ensure people were supported by staff who were suitable.

Is the service effective?

Requires Improvement

The service was not always effective.

People did not receive consistently effective support with their meals and to access healthcare services.

People's needs were not always understood and effectively met by staff.

People were supported in line with the Mental Capacity Act (2005) however improvements were required in this area.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not supported to have their privacy and dignity upheld at all times.

People's views and preferences for their care had not been gathered, to involve people in their care and ensure the care provided met people's preferences.

Although most people relatives told us staff were caring, we received concerns that this was not a consistent experience.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Although people told us they were satisfied with the care they received, we identified a breach of the regulations because people did not always received care centred around their needs and preferences. People did not have consistently good access to activities. Improvements were required to ensure complaints would always be used for learning and to improve people's care.

Is the service well-led?

Inadequate

The service was not well led.

Systems and processes were not effective to assess, monitor and improve the quality and safety of the service. This put people at risk of poor and unsafe care.

The provider had not met all of their responsibilities to the Commission.

A new manager had recently joined. Staff did not all feel supported.

St Clements Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 17 December 2018 and was unannounced. The inspection was conducted by a lead inspector, a bank inspector, a specialist advisor and an Expert-by-Experience. A specialist advisor is a professional who assists us with current practice knowledge and expertise on inspection. The specialist advisor was a nurse with a specialism in older people's care. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was the care of older people.

As part of our inspection, we reviewed the information we already held about the provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur, including serious injuries to people receiving care and any safeguarding matters. We asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. To support our inspection planning, we also checked whether information about the service was available through commissioners who help monitor the quality and safety of the home and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

Some people living at the home were not able to talk with us about their care. During our inspection, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. As part of our inspection, we also spoke with ten people, four relatives, five care staff, two nurses, the cook, the activity coordinator and three professionals involved in people's healthcare. We sampled records related to ten people's care, and recruitment files related to two staff members and two college students on placement at the home. We also spoke with the new manager, the regional manager and looked at records relating to the quality and safety of the service.

Inadequate

Is the service safe?

Our findings

At our last inspection in March 2017, we rated this key question, 'Requires improvement' because staffing arrangements did not safely meet all people's needs. At this inspection, we found improvements were still required in this area. We also identified a breach of the regulations due to the poor management of some people's risks, including medicines support. We have rated this key question, 'Inadequate'.

People's risks were not all safely managed. For example, healthcare professionals had visited one person to help treat their leg wound, and had recommended that this person required antibiotics, a week before our inspection. Antibiotics may be prescribed to people with pressure sores to treat a serious infection or an infected wound. We found the person's prescription had not been ordered, and we needed to prompt for this to be done. Although the person's care records stated the person had a grade three wound, we also saw the person's wound was not appropriately monitored by the provider, for example in line with current good practice guidelines which recommend regular measurement and recording of a wound, with photographs to help effectively assess and monitor people's risks. The person's wound was not effectively monitored and treated to ensure their safety, placing them at risk of harm.

In another example, the provider's systems showed another person's 'Malnutrition Universal Screening Tool (MUST) had deteriorated from 'low' to 'high' because the person had lost 6.7kg in two months. The provider had not prompted action to keep people safe when their risks increased, for example a referral to the dietician. We again needed to prompt for this action to be taken as it had not been done to ensure people were kept safe from the risk of harm.

Bedrails can be used to help reduce the risk of falls. Although some people used bedrails at the home, the provider failed to ensure this equipment was always used safely. For example, we saw three people's bedrail bumpers were not long enough to protect them from possible harm of the wooden bedrails. The provider's own health and safety checks had not identified this potential risk which could put people at risk of discomfort and harm through injury. Current good practice guidelines state a risk assessment for bedrail use should be carried out by a competent person taking into account the bed occupant, the bed, mattresses, bed rails and all associated equipment. Our sample of people's records found this had not been done. For example, risk assessments were either not completed or not sufficiently detailed to ensure robust consideration of the risks regarding bed rail use which placed people at risk of harm.

Some people's risks were poorly managed in relation to their medicines support. For example, one person required time-specific medicines, and regular blood tests to ensure they received safe dosages at the right times. Our sample of records found a nurse had recently had to contact healthcare professionals for help, because the person had their blood test ten days later than planned, and another nurse had not given the person time-specific medicines the day before, because they could not find the guidance about the dosages the person needed. The provider had failed to ensure the person always received safe support with their medicines.

In another example, two people told us they had refused medicines that nurses had tried to give to them

covertly. One person commented, "Sometimes at night they creep around. You are asleep and they put the medication in your mouth, no water." The second person told us an agency nurse had tried to give them medicines in error, which belonged to another person. Covert medicines administration had not been authorised for either person and we raised this with relevant partner agencies and the manager to be explored further. During our inspection, we found a tablet discarded in a communal area. We brought this to the manager's attention so they could try to identify who this tablet belonged to and what this was for. Some people told us they received their medicines safely, for example, one person told us, "I take medication and it is given at the same time every day." However, people could not be assured they would always be given their medicines safely and as prescribed.

Failure to provide care and treatment in a safe way and do all that is reasonably practicable to mitigate risks to people is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people told us they received a prompt response when they used their call bells in their rooms. For example, one person told us, "They do come quite quickly, when you press the buzzer". However, feedback we received showed there were not always enough staff to safely meet people's needs. One person told us, "You might get morning medication at noon. Depends if they are agency staff." Another person told us, "Nights are short staffed one person." A relative told us, "There are not enough staff. At night there are two care staff and a nurse in the home. People have to wait for their pads to be changed. There are residents calling for staff, I have to call them." The provider failed to ensure there were always enough staff to keep people safe, because there was no system to assess and monitor staffing levels according to the needs of all people living at the home. After our inspection, we were informed that night staffing levels had been increased in light of our findings. Day staffing levels had recently been increased however we saw staff were not always available in communal areas, although staff told us they were supposed to be present to spend time with people and to ensure people's safety. This had not been identified by the provider and there were no systems in place to ensure there were sufficient numbers of staff available to support people at all times.

One person told us, "I am safe and happy living here." A relative told us, "Yes they are safe, they look after [person]." Although people, relatives and staff told us they felt the service was safe, systems were not robust to ensure people could always be safeguarded from abuse. Staff had not all received safeguarding training to ensure they knew how to recognise and report abuse, and staff did not all show awareness of their responsibilities to help protect people. We saw some incidents had been appropriately recorded and referred to relevant partner agencies, however incidents were not consistently logged and responded to. For example, one person had sustained a number of bruises in a similar part of their body which were of an unknown cause, however these concerns were not investigated or referred to relevant partner agencies to ensure the person's safety, placing them at risk of ongoing harm.

Staff showed some awareness of people's risks and action they needed to take to keep people safe. One person told us, "I have [sore skin], they spray them and it stings, but they are getting better." Another person confirmed they were supported to reposition in bed to help relieve pressure and reduce their risk of developing sore skin. Most people told us they were supported appropriately with moving and handling, for example one person told us, "They are gentle with me." However, one person told us, "They can be a little rough when examining me. I told them they were hurting me." We saw one occasion where one person was not supported in line with current good practice. Staff had recently received moving and handling training however further improvements were required to ensure people received consistently safe support with moving and handling.

Some systems were in place to help monitor the safety of the service, for example, water temperatures were pressure care mattresses were safe and suitable and housekeeping staff helped maintain safe laundry systems. Fire safety checks were also regularly carried out to ensure staff knew how to respond in the event of a fire and maintenance issues were fixed when reported. One person's relative told us, ""I complained when the buzzer was broken in their room. It was fixed the next day." However, health and safety checks of the premises were not robust and failed to ensure people always received safe support with equipment. Guidance in people's care plans did not always clearly set out how to support people safely when using equipment which put people at risk of being supported inappropriately. The provider's own oversight had failed to identify this and concerns that we brought to their attention about bedrail use at the home.

People and relatives told us people's rooms were kept clean and people had fresh bed linen. One relative commented, "Nice and clean." Staff used personal protective equipment (PPE) appropriately to help protect people from the prevention and control of infection. However, although communal areas of the home were kept clean by domestic staff, we detected odours in other areas of the home. For example, one person's needs were not well responded to and we found the person's room had a strong smell of urine. Sufficient had not been taken to promote the person's dignity and ensure their needs could be met, in turn to also help promote safe infection control.

Since our last inspection, the provider had updated their recruitment processes at this home and at other services registered with them. This was because the provider had not followed their own processes to complete Disclosure and Barring Service (DBS) checks for all staff they employed. The regional manager confirmed this had been investigated and remedial action remained underway to address this shortfall. Our sample of a more recently recruited staff member found reference and DBS checks had been carried out before they started in their role. Copies of DBS checks had also been gathered for college students on placement at the home, and the manager confirmed a new nurse had recently been interviewed and recruitment checks were being carried out before the nurse joined the home. Systems had since been improved to ensure recruitment checks were carried out appropriately. This helped ensure people would be supported by staff who were suitable.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in March 2017, we rated this key question, 'Requires improvement'. This was because improvements were still required to promote positive mealtime experiences. This inspection found improvements were still required in this area. We also found people's needs were not consistently met including access to healthcare services. We have rated this key question, 'Requires improvement' again.

We found staff did not always show understanding of people's needs and how to effectively support people. For example, one person living with dementia was poorly supported when they were concerned that they couldn't remember where their bedroom was. The staff member told the person, "You go there so often, you couldn't forget it." This showed a lack of understanding from the staff member about the needs of this person living with dementia and how to effectively reassure the person. We saw another person gestured and tried to speak to staff, and although we tried to prompt a staff member to respond to this person, the staff member failed to do so effectively. The staff member told us, "Oh [person] does that a lot though… it's just [person's] character I guess." The staff member then responded to the person: "Do you want to talk, do you want to have a chat with me?" The person responded yes, however the staff member did not then use this opportunity to engage well with the person and lacked an understanding of their needs and how they could interact.

Staff told us another person often refused support. On the morning of our inspection, a staff member told us, "[Person] is refusing to stand up, we will leave [person] for a bit and try again." However, as the person continued to refuse support throughout the day, staff did not escalate this and so we prompted them to share our concerns with the manager. We asked the staff member what the person's known needs were and they commented, "I don't know, [person] stays in bed, [person] likes to walk around in the evening and gets lost." The staff member confirmed our observations that the person did not look comfortable but the staff member did not show awareness or confidence as to how they could act on this. Staff did not know how to respond to this person's needs and we found no information to help guide them in the person's care plan. The manager told us this person would be referred for additional healthcare support.

Most people told us they felt staff had the knowledge and skills to support them. One person told us, "They certainly do know how to look after me." Another person told us, "They are well trained, you can ask them anything and if they do not know the answer they will find out for you". We saw some staff often responded effectively to people and showed awareness of people's needs and risks. For example, we found one person's needs in relation to catheter care were already being monitored and checked on by staff. One person however said they did not feel that staff had enough skills or appropriate training for their roles. Our discussions with the manager confirmed this. A training matrix showed the majority of staff had received training in areas identified as mandatory by the provider including moving and handling training, infection control and First Aid. However, not all staff had received fire safety training, 'basic' dementia training and training about equality and diversity. In addition, staff had also not received training related to pressure care, catheter care and end of life care, although this was relevant to the needs of some people living at the home. The provider had not ensured staff had the relevant skills and received guidance for their roles and staff told us they needed to arrange and attend most training in their own free time. The manager

recognised the training and supervision needs of the staff group as a priority to improve standards at the home.

Agency staff were often used at the time of our inspection. People's feedback often showed the quality of their care was compromised by agency staff use who they felt did not understand people's needs well enough. One person told us, "The agency staff do not have the experience, they try their best." A nurse told us, "People are safe, but agency staff makes it tricky," and commented that agency staff did not always have time to read records to understand people's needs. The manager told us they had recently developed handover templates to include people's known conditions and needs in order to provide more guidance for agency staff. A healthcare professional who regularly visited the home told us this had started to help improve communication sharing between nurses and the quality of information the healthcare professional they received about people's needs. Systems were not effective to ensure people's needs would always be appropriately met and responded to at the time of our inspection.

Improvements were also required to ensure people were supported appropriately with meals, and to access healthcare services.

We identified concerns at the time of our inspection, that one person was not referred to a dietician as needed following their weight loss, and another person was not supported to have antibiotics as recommended by healthcare professionals to ensure their health. People's feedback showed they were usually supported to access healthcare services when needed. For example, one person told us, "They call the GP and they come to see me quickly." A relative told us they raised concerns about the amount of medication one person took when they first came to the home. The relative commented, "They got the doctor to come and within four days [the person's] medicines were reduced [the person's] by half."

We received mixed feedback from people and relatives about the quality of the food offered. Comments included; "It's really lovely, I look forward to it, they have a nice selection," "The food is not very good," and "It's OK". A relative told us, "My relative gets enough to eat and drink. I had lunch today with them." One person complained that their vegetables were cold. The manager and regional manager told us they recognised food had not always been maintained at a sufficient temperature for people. After our inspection, the provider told us they would introduce new equipment to help address this, including temperature probes so staff could ensure food stayed warm enough for people. Our sample of menus found that people were not routinely offered culturally varied diets to reflect the diversity of people's backgrounds at the home.

Most people spoke positively about the food on offer. We saw people were offered a choice of two meals and dessert and there were healthy options such as fruit and vegetables offered. We saw people listened to music and chatted while they ate lunch. Some people received support to eat their meals, and one person was helped to sit closer to the table so they could reach their plate with more ease. We saw that one staff member spoke to a person throughout the time they supported them to eat, and gave the person the opportunity to eat independently when possible. This was not consistent however as another person was only spoken with twice in the time another staff member supported them to eat.

We found that the design of the home was not developed as far as possible to promote people's positive experiences, and for example people's ease of access to their meals. Dining arrangements did not ensure people's comfort and ensure people could eat with ease during mealtimes. For example, we saw some people were slumped in chairs with a tray in front of them with no condiments. There were also no aids offered such as adaptive cutlery to help promote some people's independence. Although some signage and pictorial aids were on display, these were not accessible to people and effective to help engage and navigate

people around the home and promote people's independence.

Some people had décor and personal items stored in their rooms, however we found that the physical environment of people's bedrooms was not decorated to a consistent standard to meet people's needs and ensure a welcoming feel. For example, two people's rooms where they both spent long periods of time were bare and basic with no television, music or other possible activities or entertainment provided. One person had some family photos displayed but these were covered by other items and a large clock in the person's room had stopped. Communal areas where some people often spent their time had little to stimulate social interactions.
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Most people told us staff asked their permission before they provided people with support, although one person told us, "They do not ask my permission, they just do it." Another person told us, "They ask for my permission." We saw people were often supported to make their own choices and staff we spoke with understood different ways to support people to make their own choices. Appropriate support had been arranged where some people did not have the capacity to make some decisions. For example, one person had been supported to access help from an Independent Mental Capacity Advocate to ensure decisions were made in the person's best interests. A healthcare professional told us they were asked to take part in discussions to inform best interests decisions where necessary to ensure people were supported in line with the MCA.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. The manager told us that they had submitted DoLS applications for some people living at the home and confirmed these assessments were underway. However, we had not received notifications as required where some people's DoLS applications had been authorised and we saw that the provider's tracker to help monitor DoLS authorisations and applications was not accurately updated. This meant the provider did not have clear systems in place to help monitor and ensure people were always appropriately supported in line with the requirements of the MCA.

Requires Improvement

Is the service caring?

Our findings

At our last inspection in March 2017, we rated this key question, 'Requires improvement' because people's privacy and dignity were not always promoted and people were not always involved in their care. At this inspection, we found improvements were still required. We have rated this key question, 'Requires improvement' again.

A relative told us, "[Staff] are dignified and respectful to my relative." Another relative told us, "Staff do treat my relative with dignity and respect." However, people were consistently supported to have their privacy and dignity promoted. Staff told us people's room doors were left open as this was their preference. However, we found people's dignity was not always preserved, for example two people were not sufficiently covered when they were not fully dressed and bedroom doors were open. We asked staff to address this.

During our visit, we observed that one person sat on the edge of their bed, on a mattress with no sheet. Their bedroom door was left open and they were visible to people who walked by. This person was not fully clothed and although a staff member told us they had tried to encourage the person to get dressed, staff were busy supporting other people and we needed to prompt them further to encourage the person to get dressed. Staff had not ensured the person's comfort or dignity in the meantime, for example with a blanket. Despite our further prompts to staff throughout our inspection visit, we saw the person remained seated on their bed throughout the day with limited social interaction and without access to activity. Our sample of the person's care records found the person had refused all personal care over 9 out of 13 days, however no action had been taken to review these aspects of their care to explore ways to ensure this person's safety and comfort. The manager acknowledged our concerns and told us they would review this person's care with input of healthcare professionals. After our inspection, we raised a safeguarding alert in relation to this person's experiences which had not ensured their safety or dignity. We saw that another person called out for support several times throughout the day however they were not always responded to and reassured on those occasions. We saw the person remained in their room throughout our inspection visit and staff only visited to provide personal care. This person also had limited access to social interaction and activity. During lunch, we saw the person sat up in their bed and had their food spilled over their exposed legs and the bedsheet. Although the staff member knew alternative ways to prepare the person's food so this would not be spilled, this had not been done to promote the person's preferences and dignity.

Our sample of both people's records found they had not been involved in their care as far as possible, and information about their needs and preferences had not all been gathered and reviewed. For example, records related to both people's preferences including about their environment and how they spent their time were blank. Although the manager and staff informed us that one person showed new behaviours which presented an infection control risk and other safety concerns, the person's care plan had not been updated to ensure the person could be supported appropriately and to have their dignity upheld.

Most people and relatives told us staff were kind and caring. Comments included: "The staff are always kind;" "Very kind and caring;" and, "They are lovely, compassionate." However, some people shared with us, concerning feedback which showed there were times when people did not receive a caring, respectful

service and people did not feel well supported. One person told us, "Some are OK, some say if you don't like it go somewhere else." Another person told us, "Most of the staff are OK. Some bully you a bit. The night staff. The way they speak to you. If they have to change you during the night or change the bed." A relative told us, "Most are kind and compassionate, but there is one, a nurse who is very abrupt." One person told us a nurse had almost made a medicines error whereby they tried to give the person medicines that belonged to someone else. The person told us the nurse then tried to say it was a test to see if the person knew their name. We raised this with the manager for further investigation because the person told us they had already tried to complain about this but the manager had not been available. This had failed to ensure the person was treated with respect.

Failure to ensure service users are treated with dignity and respect is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This put people at risk of poor and unsafe care.

One staff member addressed a person, "Hi, how are you?" They told the person what was happening next, that the person would be offered some food and a cup of tea, and checked the person could hear the television. This showed consideration for the person and any support they may have needed.

We saw one person was reassured and told what was happening as they were supported to move using a hoist. We saw staff responded with concern when another person was upset and in pain. They told the person they would get the nurse to come and check how they were.

At our last inspection, we saw although staff were often caring, they were too focused on tasks at times to interact with people. At this inspection we identified this had not been fully addressed to improve all people's experiences. We saw staff sometimes sat with people in lounge areas but did not always make efforts to engage them in conversations or activities. As result, people often spent long periods of time without engagement and encouragement to do things of interest to them. One person's relative told us, "No activities, sometimes they don't even put the television on". People and relatives we asked told us there were "no residents meetings" here at the home.

Since our last inspection, arrangements had been made for staff to use a designated area for staff handovers so that people's needs and staff roles could be discussed privately. Although this improvement had been sustained, another necessary improvement identified at our last inspection to manage people's confidential information appropriately had not been sustained. Although people's care notes were stored in designated areas, we saw these storage areas were left unlocked and could have been accessed with ease by people and visitors. This did not promote people's privacy and dignity as far as possible and was not identified or addressed as a concern by staff or the manager.

Some staff always showed a caring approach as reflected by some people's feedback. One person told us, "They are caring, really nice." Another person told us, "The staff are friendly." We saw some warm and genuine warm interactions from some staff which people responded well to. We saw some staff had a warm and genuine approach which people responded well to. For example, we saw one person enjoyed a conversation with a staff member who showed interest in the person's life before moving to the home. Another person was accompanied by the activity coordinator to visit their friend. The activity coordinator showed concern that the person was able to visit their friend as they knew this was important to the person. The home had received some compliments for the positive and welcoming approach of staff. A relative told us, "They joke and laugh with them. They go the extra mile." A healthcare professional told us, "I think the staff who are there are quite caring and supportive, what I've observed, the care assistants and nurses have got empathy and they are caring, but think they're under pressure and time with staffing levels." People could have visitors whenever they liked. The staff and manager showed consideration for people's relatives and gave examples of how they had supported and informed them of issues when needed. Relatives told us they could contact the service when needed and one relative commented, "They have Christmas parties, we

are invited."

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in March 2017, we rated this key question, 'Requires improvement' because people's care needs and preferences were not always met. At this inspection, we still found continued concerns in these areas which amounted to a breach of the regulations. We also found improvements were required to how complaints were responded to. We have rated this key question, 'Requires improvement' again.

The provider did not ensure people's care needs and preferences would always be known and met as far as possible by the staff team. The new manager told us they had identified that people's care plans needed to be updated as they failed to reflect people's current needs and to support an ongoing assessment of people's needs. Our sample of records and observations of staff interactions and approaches confirmed this. A healthcare professional told us, "Looking at care plans I would like to see more consistency and them being completed on time including for dementia care and end of life care. When a new resident comes in, this should be done as soon as possible."

For example, two people living with dementia had no care plans in place to detail their support needs. Although staff knew one person often showed behaviours that may challenge, and the second person regularly refused personal care, there was nothing to guide staff in either person's care plan as to how their care needs could be effectively met in line with their preferences. We observed that another person living with dementia was poorly responded to when the person was concerned and couldn't remember where their bedroom was. The person was told us, "Just relax. We can't go now but if you sit down. You go there so often, you couldn't forget it." The person continued to ask to go to their room. Only one staff member was present in the communal area and staff had been instructed they could not leave this area. The person therefore could not be escorted to their bedroom by the staff member and so was instead told to calm down.

People's needs were not always met as far as possible to ensure individualised care could be provided. For example, the provider had not ensured the home was geared to meet the needs of people living with dementia as far as possible. Dementia care training had still not been provided to the activity coordinator to help them arrange appropriate and engaging activities for people that took into account their dementia care needs. We also found people were asked to make choices about their lunch meals for the next day, before their lunch the day before. We saw this disorientated one person.

Improvements were also required so that people would always receive care in line with their wishes at the end of their lives. People's end of life care plans we sampled often did not contain any information beyond burial arrangements, for example, information was not routinely gathered as to people's spiritual and cultural needs at the end of their lives. The manager told us they had identified that improvements were needed because information about people's needs and preferences had not always been gathered in relation to this aspect of their care and therefore staff would not know the person's wishes. While nobody received end-of-life care at the time of our inspection, the manager was aware that one person's needs had recently changed and they may have required this level of care in the near future. As part of the home's ongoing improvements, commissioners had also recommended the provider to develop their own guidance

around people's cultural and religious requirements for this aspect of their care.

Failure to ensure people's needs and preferences are appropriately assessed and met is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was an activity coordinator who encouraged people's involvement in activities and showed awareness of people's interests. One person told us, "I like getting my hair done. A hairdresser comes in and does my hair and paints my nails." This showed the person carried on doing things at the home they told us they liked. Staff were not able to support the activity coordinator's role to ensure people had consistently good access to activities and people's feedback reflected this. One person told us, "No activities… don't do a great deal, watch television in the lounge and fall asleep." Another person told us, "We do quizzes and exercise, I get fed up in the day. We have an activities carer, I get to play games sometimes."

Some people spoke positively about the home. Comments included: "It's good for what it does," and "I like living here". Most relatives told us they would recommend the home. One relative who told us they did not recommend the home did feel that improvements were now underway. People's individual needs were sometimes known to staff and people confirmed they were helped to have their glasses and hearing aids if they needed this. One person told us, "I have my glasses, they make sure I have them". We saw some people's other individual needs had been considered as part of their care planning, including religious and cultural needs. One person told us, "I am religious and the church elders come and visit me." Another person told us, "Someone from the church comes and gives me Holy Communion". In another example, staff and the manager were aware that some people did not speak English as their first language. One person's relative told us, "English is not [the person's] first language but there are staff who speak our language." Staff told us the rota was arranged to try to ensure staff who could speak the person's language were on shift and cue cards were used to help the person communicate with other staff. This showed consideration of the person's communication needs.

People's relatives we spoke with confirmed they were involved in people's care planning as appropriate when people moved to the home. One person's relative told us, "It was quite quick but we were well informed". Another person's relative commented, "We had a meeting me, [the person], doctor and the manager regarding their care." Relatives confirmed they had been asked information about people's likes and dislikes. We saw people were offered choices, for example what they wanted to eat and drink, and one person's choice not to attend hospital was respected and they were supported with monitored by the doctor. However, people were not routinely involved in discussions and reviews about their care. One person told us, "No care plan reviews. They have problems doing care plans." A nurse told us it had not been possible to carry out regular care reviews due to different staff on shift including agency staff at the time of the inspection. The manager had identified care planning as a priority area of improvement for the home.

Improvements were required to ensure complaints would always be used for learning and to improve people's care. Some people told us they had no reason to complain. For example, one person told us, "No complaints. I am very happy, they are a pleasant sort," and confirmed they felt able to complain if needed. Since our last inspection, the regional manager informed us they had revisited previous complaints addressed by the previous manager because they had not been responded to effectively. However, we found improvements were still required to how people's complaints were addressed and used to improve the service. Those who had complained suggested their complaints had not been fully responded to, to improve their experiences. For example, one person told us, "I have made a list of complaints. Some sorted some not." One person's relative told us they had asked how one person had sustained a bruise, but nobody knew. We shared this with the manager for further investigation. Another relative told us they had complained about one person's furniture and whilst this had since been resolved, those improvements were

significantly delayed. Information about how to complain was displayed at the home and in people's own rooms, however this guidance was not in formats accessible to all, including people whose first language was not English, to ensure all people knew how to complain and how they could expect their concerns to be addressed.

Inadequate

Is the service well-led?

Our findings

At our last inspection in March 2017, we rated this key question 'Requires improvement'. This was because systems and processes to assess, monitor and improve the quality and safety of the service were not always effective. At this inspection, this remained a concern which put people at risk of poor and unsafe care. We have rated this key question, 'Inadequate' for a second time since October 2016.

Systems failed to ensure events were always learned from to assess, monitor and improve the safety of the service. For example, the provider had received a complaint in August 2018 related to a person's catheter care. Through their complaint investigation, the provider had identified that the concerns about the person's care had in part arose from the person's unclear catheter care records. During our inspection, we found continued concerns that the person's care records were not accurately maintained to effectively assess and monitor the person's needs. The person did not have a full care plan in place and their records for example made no reference to the known risk that the person's catheter frequently blocked. In another example, incidents were not consistently logged and investigated to ensure all reasonable action was taken to ensure people's safety. For example, one person had sustained bruising in similar areas over a number of months and had more recently bruised and swollen fingers. There was no known cause of the person's injuries and we made a referral to the local authority safeguarding team as the provider had failed to identify this as necessary action to help protect the person.

Systems and processes were not effective to ensure the safety and quality of the care provided. The provider had failed to identify where people's risks were not appropriately assessed and monitored to ensure their safety. For example, two people's care plans we sampled showed they had no care plan in place related to their diagnosed condition diabetes. Both people had been supported to access some, but not all healthcare services recommended within current good practice guidelines to help safely manage their condition. Our sample of another person's care records found that information about their needs and preferences, and how to help improve their experiences of the service, had not been gathered as planned. Although records showed this person had refused all personal care over 9 out of 13 days, no action had been taken to review these aspects of their care to identify ways to ensure this person's safety and comfort.

The provider's systems and processes failed to ensure people always received safe support with their medicines. For example, we identified that attempts had been made to administer some people's medicines covertly without the appropriate authorisation, and another person did not receive time-specific medicines safely and as prescribed. Systems were not in place to identify and ensure these concerns did not re-occur in future. Medicines audits had not identified poor documentation, following that people's prescribed creams were not labelled once opened and that sharps containers were labelled and closed once full in line with current good practice for safe medicines management. The manager told us they intended to request support from the local pharmacy to drive improvements to this aspect of people's care.

The provider's systems were not robust to ensure the consistent safety of the premises and people's equipment use. During our inspection, we brought concerns to the providers attention about bedrail use which had not been identified through the provider's checks. One person told us, "My bed collapsed. A man

came the next day to fix it." During our inspection, we were informed that another person's bed had broken which meant the person needed to come out of bed into the lounge area. The manager told us they would arrange maintenance support and swap the bed with another if necessary. Whilst records we sampled showed maintenance issues were promptly addressed, this recurring concern with people's beds was not investigated in more detail to prevent this happening in future.

Before our inspection, Commissioners of the service had shared concerns with the provider about their staffing arrangements. During our inspection, although day staffing levels had been increased, we identified that staff were not always available to respond to people's needs and spend time with people. Although we were told there should be at least one staff member in lounge areas at all times, we often saw this did not happen and this was not identified by management or nurses. We received consistent feedback that there were also not enough staff at night to safely meet people's needs. We found that the provider had no system in place at the time of the inspection to help determine and ensure safe and suitable staffing arrangements in light of people's known individual dependency needs. Furthermore, our sample of records and discussion with the manager found that people's individual dependency needs were not accurately assessed due to poor care planning processes. This meant the provider had not assessed safe staffing levels or gathered necessary information to be able to make an accurate assessment.

Failure to operate effective systems to assess, monitor and improve the quality and safety of the service, and mitigate people's risks is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This put people at risk of poor and unsafe care.

Although the last CQC inspection ratings were on display as required and the regional manager demonstrated understanding of their responsibilities to the Commission, we had not always received notifications as required. For example, although the manager told us Deprivation of Liberty Safeguard (DoLS) authorisations had been granted for at least three people, we had not received notifications for this as required by law. We also had not been notified as required of one person's serious injury of a grade three pressure sore. The provider had not taken action to address concerns that two previous registered managers were still registered after they had left the service.

Failure to notify the Commission of specific events and incidents is a breach of Regulation 18 of the Health and Social Care 2008 (Registration) Regulations 2009. We are deciding our regulatory response to this breach and will issue a supplementary report once this decision is finalised.

The regional manager carried out their own audits to help assess and monitor the safety of the service and track the home's progress against the action plan issued by commissioners of the service. Records we sampled showed appropriate action had been taken in response to some incidents, for example one person had been supported to access healthcare services after a fall. The manager confirmed day staffing levels had also been increased as part of the learning from other people's falls. However, the systems and processes in place had failed to ensure people received a service which safely met their needs and the provider had not achieved a 'Good' rating in any of the key questions over four inspections since August 2015. There had not been consistent and effective leadership to help ensure the consistent delivery of high-quality and person-centred care. The last registered manager had left in June 2018 and the deputy manager had also recently left. A healthcare professional told us, "Generally the home is going through quite a lot, changes in manager and staff, so we try to support them as much as we can."

There was a new manager who had joined the service in November 2018. Our discussions with the manager found they understood the principles of good quality care and they had become familiar with people's general needs, however the manager had not yet had opportunity to implement improvements they felt

were needed, during their short time in the role. We received mixed feedback about how approachable and visible the manager was. One relative told us, "She is very approachable". However, one person told us, "No I do not know who the manager is. Did not know there was a manager." Another person told us, "The previous manager, she would come into my room and ask if I am OK, [if I had] any problems. This [new] manager stands at the end of the corridor and waves." A professional involved in people's care told us, "When [the previous registered manager] was there, meetings were very well attended, [they] knew everything about people's needs and were able to give us that feedback." The professional advised that those meetings, planned to help monitor the needs of people using the service, had not been well attended by the provider in recent months.

Staff we spoke with did not all feel supported and valued, for example one staff member commented, "They don't look after the staff, we are not happy." The staff member told us this was due to recent staff contract changes and lack of leadership. The manager had invited staff to supervisions and staff meetings to help identify and address support needs. One staff member commented, "[The manager] is really really good from what I've seen so far, if I have had any concerns/any problems, she's been on top of it." Staff had not received sufficient training and guidance for their roles, and the manager confirmed this was a priority area of improvement.

Although some were systems in place to help assess and monitor the quality of the service, these were not always effective. One person told us they had identified concerns about their care but they had not been supported to raise these concerns with the manager or regional manager: "Since that I tried to get the manager all the time… [Staff] always say 'She's not here, she will be here tomorrow', but tomorrow never comes, tomorrow when you want her she's not here again. Either he or she is not good." We raised this feedback with the manager so the person's views could be gathered and listened to. Some people and relatives had completed surveys issued about the quality of their care. The regional manager told us they had identified both positive feedback and some improvements identified from this. However, an improvement whereby people told us they had not been offered choices at mealtimes had not been sufficiently reviewed and investigated to drive improvements.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure people's needs and preferences are appropriately assessed and met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had failed to ensure service users are treated with dignity and respect. This put people at risk of poor and unsafe care.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider had failed to provide care and treatment in a safe way and do all that is reasonably practicable to mitigate risks to people.

The enforcement action we took:

Notice of proposal - conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider had failed to operate effective systems to assess, monitor and improve the quality and safety of the service, and mitigate people's risks.

The enforcement action we took:

Notice of proposal - conditions