S5 Care Ltd

George Hythe House

Inspection report

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

Summary of findings

Overall summary

About the service
George Hythe House is a residential care home that can accommodate up to 43 people across four separate wings, each of which has separate adapted facilities. They are registered to provide personal care to people aged 55 years or over with a range of physical and/or mental health needs including dementia. On the first day of our inspection there were 32 people who were living at the service.

People's experience of using this service and what we found
Care plans did not provide enough guidance to staff. Staff did not have the required skills to provide safe care. People's risks related to choking were not always safely met. Lessons had not always been learnt when things went wrong. Infection control procedures were not always followed to keep people safe from COVID-19 transmission. External professionals had been contacted, but their advice was not always clearly recorded or followed by staff.

Staff were not suitably deployed around the service. Staff were kind in their approach, but the poor staff deployment caused a task focused approach to care.

The service had undergone refurbishment since the last inspection. The provider had plans to further improve the physical state of the service.

People received activities at the service, but we received mixed feedback about the quality of these activities. Care plans recorded people's life history but there was not always clear guidance for staff to use this information in a responsive way. Relatives had made complaints, but these had not resulted in improvements in care.

People were provided with end of life care, and staff were trained to do this. Care plans for end of life care were not always holistic.

The last inspection highlighted concerns with: care records, staff recruitment, infection control, staffing levels, task focused care and auditing. This inspection found ongoing concerns in these areas. The provider has failed to oversee the required improvements. Therefore, there has been ineffective governance at the service.

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

Rating at last inspection (and update)
The last rating for this service was requires improvement (published 6 March 2021). At this inspection not enough improvement had been made and the provider was still in breach of regulations.

Why we inspected

At the last inspection, we had concerns about staffing levels and poor-quality care plans. Since the last inspection, we had received ongoing concerns about these areas. As a result of these ongoing concerns, we used our direct monitoring approach. This approach involves requesting documents from the provider and talking to the registered manager. After this process, we did not feel assured that the service safety had improved. We therefore brought the inspection forward.

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

We have found evidence that the provider needs to make improvements. You can see what action we have asked the provider to take at the end of this full report. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for George Hythe House on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment, safe recruitment, consent, and good governance.

Please see the action we have told the provider to take at the end of this report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

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

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of the provider's 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 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 responsive Details are in our responsive findings below	**Inadequate**
Is the service well-led? The service was not well led. Details are in our well led findings below	**Inadequate**

George Hythe 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.

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

Inspection team
The inspection was completed by two inspectors.

Service and service type
George Hythe House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a 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 our inspection, we used our 'Direct Monitoring Approach'. This included a review of the information we had for George Hythe House. We then requested documents from the provider and had a phone discussion with the registered manager. We were not assured by this process, so decided to complete an unannounced inspection. The information considered during our direct monitoring approach was used to help plan our inspection. We also contacted the Local Authority commissioning team and other

professionals, to understand their involvement and gather their feedback about the service.

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. We took this into account when we inspected the service and made the judgements in this report.

We used all of this information to plan our inspection.

During the inspection
We spoke with two people who used the service and five relatives about their experience of the care provided. 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.

We spoke with 11 members of staff including care staff, chefs and domestic cleaners. We also spoke with the registered manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included the relevant parts of 11 people's care records and multiple medication records. We looked at three staff files in relation to the safety of recruitment. A variety of records relating to the management of the service, including policies, training records and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with two professionals who regularly visit the service. After the inspection, we continued to receive feedback from staff members about the service.

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 requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

At our last inspection the provider had failed to robustly assess the risks relating to safety of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

Learning lessons when things go wrong

- People at the service could become distressed and anxious and display behaviour that challenged staff. Staff told us that due to low staffing levels, they did not always have time to record people's behavioural incidents. We saw that incidents were not thoroughly recorded. This meant that the provider could not be sure that people were being supported safely at these times and risks were further mitigated to prevent further incidents
- Some people's care plans identified that they needed to sit on a pressure relieving cushion to prevent skin damage. During the first day of the inspection, we raised concerns that three people who needed a pressure relieving cushion, were not using one. We saw staff were prompted by the management team to provide pressure relieving cushions, but on the following two inspection days people still did not always have the cushions they required again. Therefore, lessons had not been learnt and people remained at risk of pressure related skin damage.
- One person required a specialised diet to reduce the risk of choking. We saw the correct type of food was not provided and this resulted in the person struggling to swallow their food. Staff did not respond safely to this incident. We informed the registered manager that this person was at risk of choking. However, when we returned to the care home, we observed they were again offered an incorrect consistency drink. Therefore, lessons had not been learnt and this person remained at risk of choking on the incorrect diet. We made a safeguarding referral as we were concerned about the safety of this person's care.
- Before the inspection, one person had left the service without staff knowledge, however they had been assessed as not safe to be in the community on their own. There had been a lack of effective action to ensure this did not happen again – leaving the person at future risk.

Assessing risk, safety monitoring and management

- Some people living at George Hythe House had a diagnosis of Dementia. Care plans did not provide enough guidance for staff to support their mental health needs. Staff told us that they felt unskilled to manage behaviour that challenged them.
- One person had pressure related skin damage, but the skin damage was not recorded in their care plan to guide staff on how to care for them. A doctor had advised that one person should not be in a certain position to prevent skin breakdown, but we saw this advice was not followed by staff until the following morning.

This poor-quality care puts people at risk of pressure related skin damage.
● Kitchen staff did not understand people's dietary needs and risks. The written guidance for kitchen staff to follow was poor quality as it did not have the detail required. This put people at risk of having unsafe diets.
● People were at risk of poor diabetic and epilepsy support because care plans did not provide sufficient guidance to staff and staff had poor knowledge of how to support these health needs.

Preventing and controlling infection

● The inspection occurred during the COVID-19 pandemic. The care staff did not wear face masks correctly, as the government guidance required. Staff wore hand jewellery and had painted fingernails. This does not allow safe infection control processes for hand cleanliness. This puts people at risk of COVID-19 transmission.
● We were not assured that the provider was meeting social distancing rules. People at the service were sat close to each other in communal areas. This did not follow the service's infection control processes and put people at risk of COVID-19 transmission.
● The service policy was to use specific cleaning mops in specific areas of the home. For example, one mop for a communal area, and another mop for a high infection risk clinical area. We found that these mops were not used in their designated areas; increasing the risk of bacteria transmission around the care home.

We found that systems in place put people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider has created an action plan so improvements can be made. We will assess the impact of this at our next inspection.

● Visitors had covid tests before entering the service. This helped to prevent visitors from spreading infections. We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider's infection prevention and control policy was up to date.

Staffing
At the last inspection, the provider had not ensured people received care from sufficient numbers of staff who were suitably qualified, skilled or competent. These concerns constituted a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● The last inspection found that staff were not suitably deployed around the building. Staff had to leave areas unattended to support other staff. We found staffing levels across the care home had not changed, staff told us that leaving areas unattended was an ongoing concern. This left people at risk of not having their needs met in a timely way.
● We saw that there were not enough staff to respond to people when they displayed behaviour that required support. A person was observed to display behaviour that resulted in an injury to themselves. Staff were too busy supporting other people to notice this and therefore did not respond to reduce the risk of harm. Another person was observed to be eating a banana peel putting them at risk of choking. There were no staff nearby to observe and intervene. The inspector therefore had to alert staff to the risks.
● We expressed concerns about people's mental health needs not being met safely. The provider responded

by increasing the amount of observations required from staff. Four staff told us that staffing levels had not changed with these increased observations. They said they did not have enough staff to check on people more often.

● Seven care staff told us that there were not enough staff deployed to meet people's care needs. One staff member said, 'We are run ragged', another said 'If people's needs increase, we don't get more staff, we just have to run faster.'

We found that there were not enough staff to keep people safe from harm. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We looked at three staff member's recruitment records. In all three records, we found the provider's recruitment policy was not followed to ensure that staff were safely recruited.

● Concerns included large gaps in work/training history that were not accounted for, and suitable references not being gathered to ensure the staff member had a good character.

We found that staff were not safely recruited. Staff also did not have the competence and skills to deliver safe care (reported in detail in the effective section of this report). This was a breach of regulation 19 (fit and proper persons deployed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● We saw that people's needs were not always met in a timely and appropriate way. This has been reported throughout this safe section of the report, with examples like not receiving pressure cushions as required, not having the appropriate diet, and behaviours not being responded to safely. This could lead to neglect.

● Staff had received safeguarding training. They knew how to recognise potential abuse and had raised some concerns about poor quality care to us before the inspection occurred.

● The two people we spoke to told us that they felt safe at the service. Surveys sent out by the provider in October 2021, showed people felt safe living at the service.

Using medicines safely

● Staff were not provided with sufficient guidance to safely administer 'as needed' medicine. For example, one person needed medicine if they had an epileptic seizure. There was no guidance on what type/length of seizure would require this medicine, or what to do if the medicine was ineffective.

● There was not always medicine trained staff at the service overnight. An on-call system was used, to bring a staff member in if medicines were required at night-time. This process may not allow people to receive their medicine in a timely way. The provider told us they are now ensuring medicine trained staff are available at night-time.

● Medicine was stored at the appropriate temperature and in a locked room.

● Staff clearly recorded when routinely prescribed medicines were given.

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 requires improvement. At this inspection this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- Staff were not adequately trained to meet people's individual care needs. For example, the provider had failed to ensure kitchen staff had received necessary training on amended diets to meet the needs of people who had been assessed as being at increased risk of choking.
- Care staff had not received epilepsy training and had poor knowledge of how to respond if a person had an epileptic seizure. This put people at risk of their epilepsy being responded to in an unsafe way.
- Care staff told us they did not feel confident in how to respond to behaviours that challenged them. They told us that they sometimes avoided supporting people who display behaviour that challenges them. This increases the risk that a person may injure themselves or others.

Staff did not have the competence and skills to deliver safe care. We also found that staff were not safely recruited (reported in the Safe section of this report). This was a breach of regulation 19 (fit and proper person s deployed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Since the inspection, the provider has told us that they have arranged training for kitchen staff. They have also arranged epilepsy and challenging behaviour training. We will review the impact of this training at our next inspection.

Ensuring consent to care and treatment in line with law and guidance

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

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

- People who struggled to make decisions for themselves, had not always had their mental capacity assessed by the provider. For example, one person had mental ill health and did not always agree to

receiving washing and dressing support. This put them at risk of being unclean and undressed. There was no mental capacity assessment into this person's decision making. There was a lack of clear guidance on how staff should respond to this person's non-compliance.

● Staff were not always aware who had a DoLs authorisation in place, and whether there were conditions associated with the authorisation. This meant staff were not always aware if restrictions were legally authorised or how they would meet the conditions of those authorisations.

● One person's mental ill health assessment required their medicine to be given covertly (hidden in their food). This is because they did not have the mental capacity to understand their need to take medicine. The person's doctor had specified the person should still be offered this medicine overtly once a week. However, this had not been happening, which meant the prescriber's instructions were not being followed. This risked the person continuing to be given hidden medicine's, when their acceptance of this medicine may have changed.

People were not effectively supported in line with the mental capacity act and deprivation of liberty safeguards. This was a breach of regulation 11 (consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

●Care records were not written in line with current standards. This meant staff did not always have effective guidance on how to support people's needs. For example, a Waterlow assessment tool is a nationally recognised risk assessment to understand a person's risk of pressure related skin damage. This tool had been used and highlighted that a person was at risk of skin damage. However, this has not been reflected into a clear care plan for staff to follow. Staff did not have guidance on how often this person required support to reposition. This ineffective application of the Waterlow tool into a good quality care plan, put the person at risk of irregular repositioning and skin breakdown.

● Staff did not always keep appropriate records on the care that they had provided to people. Staff told us that they struggled to complete written records to the required standards due to their limited time and low staffing levels. Keeping accurate and comprehensive records is important to understand what care has been provided and understand whether a person's care needs are changing.

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

● Some people were not always given the texture food/ drink that was prescribed by external professionals. This can affect their risk of choking. The provider has told us they have taken action to ensure improvements are made.

● People received enough food and fluid to ensure they were not at risk of malnutrition or dehydration.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● Staff referred to other professionals as needed. For example, they contacted a doctor if a person was unwell.

● While referrals were made, external professional advice was not always clearly documented in the person's care plan for staff to follow. This poor care planning could impact the effectiveness of care. For example, a professional had been contacted for advice on how to respond to a epileptic seizure. However, the care plan for this person was poor and there was not guidance for the 'as needed' medicine in place.

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

● Since the last inspection, there has been substantial refurbishment to improve the environment at George Hythe House.

● We received mixed feedback about the quality of the refurbishments. Relatives spoke positively that the refurbishments had occurred but felt the home could feel more homely and personalised. The nominated individual advised that they have an ongoing plan to further improve the service. This plan included making the service more personalised.

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 requires improvement. At this inspection this key question has remained the same. This meant people were not always well-supported, cared for or treated with dignity and respect.

Supporting people to express their views and be involved in making decisions about their care; Ensuring people are well treated and supported; respecting equality and diversity

- Staff told us that due to low staffing levels, interactions with people were often rushed. Rushed care can impact the kindness of the interaction. A relative told us "There is no time for social chat."
- When staff did talk to people, we saw their interactions were kind and polite. Staff were able to describe how to provide caring interactions, but explained that staffing levels and rushing can impact the quality of their interactions.
- There was an equality and diversity policy in place at the service. Care plans provided guidance on people's diverse needs. Staff were able to describe the importance of equality.

Respecting and promoting people's privacy, dignity and independence

- Due to staff being otherwise occupied, we observed that people's dignity was not always supported in a timely way. At meal times, people had food around their mouths that was not cleaned by staff in a timely way. We saw multiple recorded complaints from relatives about the poor presentation of people.
- Staff were able to describe how to provide people's need for privacy. For example, using curtains and shutting doors during personal care

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs. At the last inspection this key question was rated as requires improvement. At this inspection this key question had deteriorated to inadequate. This meant services were not planned or delivered in ways that met people's needs.

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

- Staff were focused on completing tasks, rather than providing person centred care. One staff member told us, "Sometimes people aren't moved to their bedrooms after lunch, because we would have to bring them back to the dining room for their tea." A relative told us "Everything is based on getting tasks done." The focus on task centred care is an ongoing concern from the last inspection.
- Some information had been gathered on people's interests and life history. However, this information gathering was minimal and lacked detail on how staff should use this information to provide personalised care.
- Care plans did not always have accurate information for staff to follow. One person's care plan described that they were 'very sociable and liked to sit with other residents and have a chit chat'. However, we saw, and relatives confirmed, that this person had limited verbal communication and did not engage with other people at the service. This inaccurate care plan meant staff did not have suitable guidance to support the person's needs.

End of life care and support

- People had end of life care plans in place which did not always include important information about people's wishes. These care plans were not always holistic, to describe people's emotional, social and cultural needs.
- Due to staffing levels, and a task focused culture, there was an increased risk that end of life care would not be provided in a responsive way, meeting people's preferences and holistic needs.

People did not receive person centred care. This was a breach of regulation 9 (person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

- Complaints were not responded to appropriately by the provider. We saw multiple recorded complaints about the unclean presentation of people. During the inspection, staff were sometimes slow to ensure people were well presented. Ineffective action had been taken after complaints were made to improve care.
- We saw multiple recorded complaints about people's personal items being lost around the care home. During the inspection, relatives told us that this was an ongoing concern. They felt effective action had not been taken after their complaints had been made.
- We considered the complaints that relatives told us they had made. These complaints were not always recorded and responded to as the company policy required.

Complaints were not appropriately responded to. This was a breach of regulation 16 (receiving and action on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The service had an activity co-ordinator, who arranged for people to have access to daily activities. We received mixed feedback about the quality of these activities offered to people and the relevance to people's interests. One family member described that they visit regularly as they were concerned that the person was under stimulated.
- Staff encouraged friends and family to visit people. This reduced the risk of social isolation.
- People's social and religious needs were recorded in care plans. So, staff could provide suitable support.

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.

- There had been complaints before and during the inspection of hearing aids, dentures and glasses going missing. This can impact people's communication.
- People's sensory needs were recorded in their care plans, so staff could understand how to support people's communication needs. However, due to the lost communication aids this was not always easy for staff to do.
- Staff communicated with people in a way they understood, and by using clear language
- The registered manager explained that they had access to different formats (For example, larger font writing) if needed to aid communication.

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 requires improvement. 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At the last inspection, the provider failed to ensure robust systems were in place, and that required improvements were made to the service. This was a breach of Regulation 17, (good governance), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● There was a low morale at the service. In March 2021, the nominated individual told us that they were working on improving the poor staff culture at the service. At this inspection, staff told us that the culture remained poor and morale in the staff team was low. There had been ineffective action to improve this culture.
● Staff reported that their work was focused on achieving tasks rather than providing person centred care. One staff member told us "They (staff) don't treat people like people. They are just a job. I wouldn't bring my relative here."
● Our last inspection found that record keeping was poor quality, we found poor record keeping was an ongoing concern. The nominated individual told us that they now had improved audits in place, but we found these audits were not effective at creating the required improvements to care records.
● We had concerns about the numbers of staff deployed at the service. The registered manager used a tool to calculate how many staff were required at the service. The provider had not effectively used this tool to ensure the needs of people had been assessed and staffing levels were sufficient to meet those needs
● People had personal emergency evacuation plans, to guide staff on how to safely evacuate the person in the event of an emergency. We found these evacuation plans were poor quality. The registered manager did not have effective oversight to ensure these evacuation plans met expected standards.
● During our inspection, we expressed concerns about the safety of the service. We saw that during the morning handover meeting, staff were asked to make some changes to the way they provided care. However, this instruction was ineffective as we continued to see poor care provided. The handover process was therefore ineffective.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The registered person is legally required to notify us of any DoLs authorisations they had received. They

had not done this. This is an ongoing concern from the last inspection.
● Relatives told us that they did not always have clear communication from the service. One relative gave the example that a person had gone into hospital and they had not been informed.
● The provider did not always follow their own complaints procedure. The provider's complaints policy required all complaints to be responded to in writing. This had not always happened.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Staff views on the responsiveness of the service had deteriorated since the last inspection. The provider had asked staff for their feedback in surveys. In April 2021, 41% of staff felt the responsiveness of the service needed to improve. We saw that in October 2021, this feedback had increased to 63% of staff reporting that responsiveness needed to improve. There had been ineffective action by the management team to improve this feeling in the staff team.
● Some relatives reported that they were not always involved with the service. No relative's meetings had occurred in the last year.

Continuous learning and improving care
● The provider had failed to achieve improvements in care. The last inspection highlighted concerns with care records, staff recruitment, infection control, staffing levels, task focused care and auditing. This inspection found ongoing concerns in these areas. The provider has failed to oversee the required improvements.
● During the inspection we raised concerns with care planning, pressure related skin care, choking and behavioural support. Ineffective action was taken during the inspection to resolve these risks.

Working in partnership with others
● Where people required external professional involvement, then referrals were made. However, feedback from professionals was not always clearly recorded or followed by staff.
● For example, one person was diagnosed with diabetes and required a diabetic suitable diet, however their diabetic needs were not clearly recorded and kitchen staff were unaware of these dietary needs. We asked the registered manager to take action. When we returned, the kitchen staff had received written diabetic guidance for this person. However, we identified that another person's guidance was missing. There had been ineffective action to review and improve all diabetic guidance risks

The provider failed to oversee the required improvements to the service. Audits were not effective. This was a breach of Regulation 17, (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since the inspection, we have been sent an action plan, describing how improvements will be made. We will assess the impact of this action plan at our next inspection.

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 11 HSCA RA Regulations 2014 Need for consent People were not effectively supported in line with the mental capacity act and deprivation of liberty safeguards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not suitably deployed around the service

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 We found that systems in place put people at risk of harm

The enforcement action we took:

We have imposed conditions on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to oversee the required improvements to the service. Audits were not effective.

The enforcement action we took:

We have issued a warning notice. This requires the provider to be compliant with this breach in a specified time frame. We will then review improvements made.