London Residential Healthcare Limited

Chestnut House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Chestnut House Nursing Home is a residential care home providing personal and nursing care up to 85 people. At the time of the inspection there were 45 people living at the service, the majority of whom were older people living with dementia.

People's experience of using this service and what we found
The service was not consistently well led. The governance systems in place had not been fully effective in identifying shortfalls in the quality of the service and then improving the quality of the service. The monthly improvement plans submitted to CQC by the registered manager did not reflect the findings and shortfalls found at the inspection. The provider was responsive in providing management cover and support following the departure of the registered manager during the inspection. The provider had identified there had been a deterioration of how well led the service was in the weeks prior to the inspection and had a plan in place to fully assess the service prior to this inspection.

There were safeguarding systems and procedures in place and staff knew how to report any allegations of abuse. However, some people were not always safe from abuse or harm from other people living at the service. Safeguarding measures put in place were not always effective.

Risks to people were not fully assessed or managed to minimise the risks to people. Staff did not have the experience, skills or knowledge to meet the needs of those people living with dementia, mental health needs, autism and complex nursing needs.

There was a very stable nursing staff team and core team of care staff. However, there had been a very a high staff turnover prior to the inspection and there was high use of agency and new staff. There were shortfalls in the information available about the suitability of staff and agency staff.

People's' needs were not fully assessed and planned for. Assessments and care plans in place did not fully reflect people's needs and preferences, they were inaccurate and did not give staff the information and guidance they needed to be able to care for people. People's life history and experiences were not used to develop personalised care plans. This meant people did not always receive the support they needed to meet their care, welfare and well being needs.

People were not consistently supported to have maximum choice and control of their lives. Staff supported people in the least restrictive way possible and in their best interests but this was not always recorded; overall, the policies and systems in the service supported this practice.

People enjoyed the food, but they had mixed experiences at mealtimes in the way they were supported by staff.

Staff were mostly kind and caring and were fond of people. However, we observed some staff ignored some people who called out or were anxious, upset or difficult to engage with because they were living with dementia or did not communicate verbally. Overall people's dignity was maintained.

There were group activities provided and people clearly enjoyed these. However, people spent long periods of time without any stimulation or having anything to occupy them. People who spent time in their bedrooms were at risk of social isolation.

People and relatives knew how to complain but complaints were not investigated in line with the provider's policies. Actions and learning from complaints were not implemented to improve the service people received.

There were significant improvements in the monitoring of people's fluid intake and the monitoring systems. People's health needs were well managed, and people were referred to health care professionals appropriately.

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

Rating at last inspection
The last rating for this service was Requires Improvement (published 8 November 2018) and there was an ongoing breach of regulation relating the governance of the service. A condition of registration had been imposed on 5 March 2018 requiring the service to provide CQC with a monthly report on the actions following the service's audits of people's care plans and any risks they faced. The registered manager had submitted some monthly action plans to CQC. However, these were not consistently provided and did not meet the condition imposed. At this inspection enough, improvement had not been made and sustained and the provider was still in breach of regulations.
This service has been rated requires improvement or inadequate for the last three consecutive inspections.

Why we inspected
The inspection was prompted in part due to concerns received about the conduct of the registered manager, safeguarding incidents between people and staffing concerns. A decision was made for us to inspect and examine those risks. The inspection was also prompted in part by notification that a person using the service sustained a serious injury. This inspection did not examine the circumstances of the incident and this was reviewed separately.

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

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

The provider took immediate action to mitigate the risks to people and further actions following the inspection.

Enforcement
We have identified breaches of the regulations in relation to safeguarding, safe care and treatment, person centred care, staff recruitment and the leadership and oversight at this inspection.

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

We have imposed conditions on the provider's registration to ensure compliance with the regulations.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme.

We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Chestnut House Nursing Home

Detailed findings

Background to this inspection

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

Inspection team
Two inspectors, one assistant inspector, and a nursing specialist advisor.

Service and service type
Chestnut House is a nursing care home. People in care homes receive accommodation and personal care. 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. The registered manager left the service with immediate effect during the inspection and cancelled their registration. The provider made arrangements for the management of the service whilst they recruited an interim manager.

Notice of inspection
This inspection was unannounced.

What we did before the inspection

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 reviewed information we had received about the service since the last inspection. This included details about incidents the provider must notify us about, such as serious injuries and safeguarding incidents and also any concerns raised with CQC by members of the public. We sought feedback from the local authority and clinical commissioning group (CCG) who funded people's care at the service. We used all of this information to plan our inspection.

During the inspection
During the inspection we met all the people and spoke in detail to 10 of them to ask about their experience of the care provided. Eight relatives spoke with us and we had an email from another relative via the service. We spoke with 18 members of staff including care assistants, senior carers, nursing staff, the head of care, the registered manager and representatives of the provider. We also spoke with two visiting health professionals.

We reviewed a range of records that included five people's care plans and multiple daily monitoring charts and medicines records. We also looked at a range of documents relating to the management and monitoring of the service. These included five staff records, agency staff profiles, complaints records, audits, policies and maintenance checks.

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.

After the inspection
We received information from the provider as agreed at the end of our inspection site visits. This included information related to staff training, staffing information, quality assurance systems, staffing levels and end of life care. We received email and telephone feedback from three relatives.

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.

Systems and processes to safeguard people from the risk of abuse

- There were safeguarding systems and procedures in place and staff knew how to report any allegations of abuse.
- People were not always safe from abuse. This was because there had been a number of safeguarding incidents prior to and during the inspection dates where people had been harmed. This related to one person whose behaviour had changed significantly and they were physically harming other people and staff. The safeguarding measures initially put in place by the service had not reduced the risks to people.
- We raised a safeguarding concern with the local safeguarding team during the inspection regarding the alleged abuse of one person who was challenging both the service and other people.
- Not all safeguarding concerns were identified and reported to the safeguarding authority. For example, safeguarding concerns in complaints had not been identified, referred to the safeguarding authority, CQC and actions were not taken to minimise the risk of reoccurrence.

The failure to protect people from abuse was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider took steps during the inspection to reduce the risks of people and staff being harmed and worked closely with health professionals, the safeguarding authority and the police.

Assessing risk, safety monitoring and management

- Risk management plans were not always in place, so staff knew how to safely support people. For example, two people had epilepsy and they did not have any epilepsy management plans in place. This placed them at risk of harm because staff were not aware of what the plan was should these people have a seizure. The nursing staff took immediate action and put these in place.
- Some staff did not move people safely and use the equipment detailed in their care and risk management plans. For example, two staff supported one person to move from an armchair to a wheelchair without using a moving and handling belt as described in their care plan. This put the person at risk of falling and or being injured by staff who used unsafe moving techniques.
- The information in risk management care plans to guide staff was limited. They did not include all details such as the potential triggers that were likely to upset people that could lead to these behaviours that could challenge staff or other people, and how and what to say and do to reassure people. This lack of information and guidance on how to support people when they were unsettled, upset or anxious meant staff were not

always able to minimise the risk of incidents occurring.
● Some staff were not confident or skilled in supporting people when they demonstrated behaviours that put them or others at risk. Some incidents had led to people that used the service becoming aggressive towards others. This placed people, the staff team and potentially visitors at risk. In addition, staff had needed to physically intervene during incidents to make people safe and they had not been trained to do so. This placed people at risk of harm and injury.
● Most people being cared for in their bedrooms had access to their call bells, so they could seek assistance. However, one person did not have access to their call bell when they needed assistance. We gave the person the call bell so they could seek help. Two people, who were living with dementia, were not able to use call bells were repeatedly ignored when they called out from their bedrooms. This placed these people at risk of not having assistance when they needed help.
● At a previous inspection in May 2018 people were sat out in the sun but were not given any protection such as sunblock or sun hats. At the last inspection staff had received specific training and guidance in regards keeping people safe. However, at this inspection one person had been sun burnt the day prior to the inspection. This was because staff did not have the skills or understanding of the person's conditions to support them to understand the importance of sun cream and shade.

These shortfalls in the assessment and management of risks was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider took steps during and following the inspection to reduce the risks to people, this included starting to review and update people's risk management plans and a daily walk round with the acting manager and lead nurse for the day to check people's call bells and welfare. We have not been able to test the effectiveness of these actions and the impact these will have on people. We will review this fully at the next inspection.

● Equipment, such as lifts and hoists were checked by external contractors to ensure their safety. However, day to day maintenance was not always effective. This was because repairs to people's bedrooms were not always completed or followed up. This was an area for improvement and the provider agreed to review the systems in place for the management of maintenance.
● People's records were not always accurate, and they did not reflect people's experiences and how they had spent their time. This was an area for improvement and the provider took action to review the record keeping and ensure that it was more personalised. They told us they were planning to introduce electronic care planning and recording systems.
● At our last inspection there was a risk that people might not be evacuated in a timely way in the event of an emergency. This was because the Personal Emergency Evacuation Plans [PEEP] for people and staff were not in place. At this inspection there were accurate PEEPs in place for both people and staff living at the service.

Staffing and recruitment
● Recruitment procedures did not consistently make sure people were supported by staff with the appropriate experience and character. This was because the recruitment information about the suitability agency staff, who lived at Chestnut House Nursing Home, was not available. In addition, a negative reference had not been followed up to ensure the suitability of a staff member employed by the service. This meant there was a risk that unsuitable staff may be working with people.

The shortfalls in in staff recruitment procedures was a breach of Regulation 19 (Fit and Proper Persons Employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The provider took steps following the inspection to follow up on references and obtain full information about agency staff that lived in the service. We have not been able to test the effectiveness of these actions. We will review this fully at the next inspection.

● There was a very stable nursing team at the service with most of the nursing staff being at the home for over three years. However, there was not a stable care staff team, nine care staff had left the service the eight weeks prior to the inspection. This high turnover of staff was having a negative impact on people. This was because some staff did not have the skills to safely meet some people's needs. For example, there were people living at the service who were living dementia, complex mental health conditions and autism. Some staff did not know people well, had not been trained or did not have the skills to understand and meet some peoples' complex needs. This resulted in these people being placed at risk of potential and actual harm and their needs not being met.
● There were mixed views from relatives as to whether there were enough staff. One relative told us, "There is a lack of staff just when you think everything is going well there's another tsunami of staff leaving".
●During the inspection there were enough staff on duty. However, there was a high use of new and agency staff who did not know people well. This lack of knowledge of people impacted on the quality of care and support they received.
● A tool had been used to calculate staffing levels, based people's dependency. Staffing rotas showed that the four weeks prior to the inspection staffing levels had not been maintained at the levels determined by the dependency tool to enable staff to support people safely.
● The staff rotas did not include the names of agency staff that worked. This meant there was not any effective management oversight as to how many staff actually worked each day. This was an area for improvement and at the inspection the provider agreed to include the names of all staff working on the rota.

The shortfalls in staffing and staff skills and knowledge were a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The provider took steps following the inspection to arrange further dementia and specialist training for staff in September 2019. We have not been able to test the effectiveness of these actions and the impact these will have on people. We will review this fully at the next inspection.

Learning lessons when things go wrong
● There were systems in place to ensure accidents and incidents were recorded, investigated and action taken. The provider and registered manager had ensured that accidents and incidents were analysed for trends and patterns. For example, they had used the information to identify people who were at high risk of falls or were being involved in safeguarding incidents. These people were discussed at staff handovers and the morning briefing meeting. However, this follow up had not always resulted in actions being taken to minimise the risks of reoccurrence. For example, one person had been sunburnt, so actions had not been implemented following the last person being sunburnt.

Preventing and controlling infection
● People were protected from cross infection. Overall the service was clean and odour free and communal areas were clean. However, some bedrooms and people's bedroom furniture were not clean. This was an area for improvement and the provider agreed to address this by the manager on duty completing a daily walk around the service.
● Staff had completed infection control training and used protective clothing such as gloves and aprons during personal care to help prevent the spread of healthcare related infections.

Using medicines safely

- People were supported to take their medicines as prescribed and in ways that met their preferences.
- Medicines were safely obtained, stored, recorded, administered and disposed of. Systems were in place for medicines that required cool storage and medicines that required additional security.
- The medicine administration records (MARs) provided contained the detail necessary for safe administration.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- People's needs were assessed prior to moving into the service but consideration was not always given as to whether staff had the skills and knowledge to be able to meet people's needs before they moved in. This meant some people were not receiving effective care.
- People's ongoing assessments and care plans were not always accurate, to make sure staff knew what care and treatment to deliver. For example, one person needed oxygen 24 Hours a day. Their assessment and care plan did not include information how to transfer the person from the oxygen concentrator to cylinder oxygen, which was used when they were in their chair or wheelchair. Another person's care plan did not describe how to manage their catheter. This was important as the person's catheter was prone to complications.
- Some people did not receive effective care and treatment. This was because the care they needed was not delivered. For example, one person, who was at risk of pressure damage, was not repositioned or taken to the toilet as detailed in their care plan. They were not repositioned or taken to the toilet from 7.40am until after 1.30pm.
- People's care was not delivered in line with their assessments and care plans. For example, one person was given foods whilst they were not alert and had their eyes closed. Staff tapped the person's lips and pushed food in to the person's mouth even though they pursed their lips tight to indicate they did not want the food. Staff did not talk with or encourage the person whilst they were doing this. This person was not supported as detailed in their care plan and this placed them at risk of choking.

Shortfalls in the risk management, planning and delivery of safe care was a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- People did not always receive effective care by staff who had the skills to support and care for them. This was because most staff had not received more specialist training such as dementia care, epilepsy, positive behaviour support, mental health needs and autism.
- Staff completed an induction course and had mandatory training updates periodically. There was a mix of online and face to face training. There were weekly training sessions for moving and handling, MCA & DOLs, safeguarding, infection control and fire training.
- Staff training had not been kept up to date in line with the provider's guidance. 20% of the staff team were

not up to date with the provider's online training and 16% of the staff team had not completed or were out of date with the provider's face to face training.
● There was not a robust system to ensure agency staff had an induction when they came to the service.
● There were mixed and contrasting views from staff as to how well they had been supported by the registered manager. The provider's head of human resources planned to be at the service for sessions following the inspection, so staff could access support. Staff had supervision sessions and annual appraisals with their direct line managers.

The shortfalls in staff training and agency staff induction were a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.The provider's action plan showed that all staff, including agency staff were booked on to training and it was anticipated this would be completed by the end of September 2019.

Supporting people to eat and drink enough to maintain a balanced diet
At our last inspection the systems for monitoring people's food and fluid intake were not effective.

At this inspection there were systems for the daily totalling and monitoring of people's fluid intake. Where there were any shortfalls in people meeting their fluid targets this was shared with staff at handovers. Staff then encouraged people to drink more to reduce the risks of dehydration. Where people were at risk of poor nutrition and dehydration there were care plans in place. Their daily food and fluid intake and weight was closely monitored. People were referred to dietician's following any weight loss.

● The chef had a good understanding of how to support people on modified or specialist diets, such as those who needed a softer diet due to swallowing difficulties.
● People told us, and we saw they enjoyed the meals provided. People had access to drinks and snacks throughout the day.
● People had mixed experiences at mealtimes or when they were supported to eat and drink. Some people were supported sensitively by staff who sat and chatted with them and explained what they were eating. They were given visual and verbal choices of food and drinks so they could say or gesture what they wanted to eat and drink. However, some people were not supported to eat and drink at the same time as other people and were waiting for a long time whilst other people were supported.

Adapting service, design, decoration to meet people's needs
● The home was purpose built and bedrooms were spacious and had en-suite toilets and shower rooms. Memory boxes had been developed and placed outside most people's bedrooms.
● There was signage throughout the home that was dementia friendly.
● There were communal lounges and separate dining areas. The lounges had sofas and armchairs with small seating areas. However, the staff offices had large windows that looked directly into the lounge areas. This was not conducive to a relaxed homely feel in the lounge areas and resulted in people being watched by staff from these offices.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People had their healthcare needs met. Health professionals told us timely and appropriate referrals were made to specialist teams.
● People and relatives told us they or their family members received medical input when they needed it.
● The nursing staff team had worked to develop positive working relationships with local health professionals.

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.

● There was a system in place to ensure that where DoLS were authorised, these were monitored, and any conditions were clearly recorded.
● Where people lacked capacity, mental capacity assessments were undertaken. People's legal representatives, relatives and professionals were consulted and involved in best interest decisions. However, this was not consistent, and some people did not have MCA assessment and best interest decisions in place. For example, one person had a falls sensor in use, but this decision had not been made in line with the MCA.

● Staff had a basic understanding of the MCA and the principles of making any decisions in people's best interests.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement.

This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

● People's experiences were very mixed. Most staff were committed to providing a very caring service and did so with kindness and compassion. There were some very relaxed and chatty, friendly interactions between staff and people. However, some staff ignored people when they were visibly uncomfortable, anxious, were calling out, withdrawn or upset. This affected their well being and people either became more upset or withdrew into themselves and stopped engaging with other people and the things around them.

● Relatives gave us contrasting and mixed views about how well people were treated and supported. Relatives told us, and we received positive comments about people's experiences. One relative wrote in an email, 'I am just writing to say on behalf of us all, how pleased we are with the care that Mum has been receiving from all your staff. She is so happy and talks fondly of everyone. Nothing appears to be too much trouble.' However, another relative told us about when their family member needed the toilet and they asked staff for help and they were told they had not got time. They told us "it seemed like it was too much trouble".

The provider informed us following the inspection, they had reviewed the staff induction and training programmes. This was to make sure staff had a better understanding of how to ensure people were treated in a caring way and so staff fully respected people.

● Long standing staff clearly cared about people and spoke fondly about people. The provider sent us examples of what the staff were proud of and what they had done that had a positive impact on people's well being. These examples included when a staff member had brought their kitten in to show one person who loved cats. The person rarely spoke at all and they smiled and repeatedly said how lovely it was to see the kitten. The staff also gave people red roses on valentine's day and one person told them, "I feel so special thank you".

Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care

● People's dignity was not always respected. Staff did not ask people whether they wanted aprons on before they ate. They put them on whether people wanted them or not. The aprons used were faded, worn and the way in which these had been placed on people without seeking their consent did not respect that people were adults. This was an area for improvement and the provider confirmed following the inspection they had ordered new clothes coverings and that people were asked if the wanted them on.

● Overall, staff were observed to knock on people's doors before entering and be discreet when people needed assistance.
● Most staff gave reassurance to people when they were providing support. However, there were some staff who did not ask people's permission or explain to people when they provided care or support.
● There were some examples of people's independence being promoted. For example, people being encouraged to walk to maintain their strength and mobility. People had specialist cutlery and crockery so they could eat themselves.
● Some people's care records held information about how to support people with choices. However, the high use of agency staff and staff who did not know people well, meant that staff did to always know how people made important or day to day choices.
● In the main information was stored securely. People could be assured their confidential information was only accessible to people who had the right to access it. However, one person's care records were left by staff in a corridor.
● Visitors told us they were made to feel welcome and there were no restrictions on when they could visit.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires improvement.

This meant people's needs were not always met.

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

●Care plans were not person-centred and did not tell staff how and when people preferred to receive their care. However, staff who had worked at the service for a long time spoke about people in a person-centred way and knew people's likes and dislikes as well as their personal routines.

● We were told by the registered manager that care plans were reviewed monthly and they were up to date. However, we identified multiple shortfalls in the accuracy of people's care plans. This meant staff did not have up to date care plans to follow to meet people's needs. For example, one person had dried wounds on their face, but their care plan stated their skin was intact. Another person's care plan included the person walked with two staff and using a walking frame. However, the person was no longer walking with staff and was being transferred to a wheelchair. A third person was supported to walk in a way that differed from their care plan.

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.

● Most people's communication needs were identified in their care plans. However, they did not describe how staff were to meet them. For example, for people living with dementia, care plans included phrases such as give the person 'reassurance' but did not detail what things, phrases or subjects would reassure them and how to communicate this to them.

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

● People who spent time in their rooms, as well as those who were living with dementia and were more reliant on staff to meet their needs, were at risk of social isolation. Staff were observed to be busy and task focused. There were many missed opportunities to interact and engage with people. This was also partly due to the staff's skills in relation to being able to engage with people who were withdrawn or living with dementia or did not communicate verbally.

● People's histories, interests and what was important to them was not used to develop care plans and provide personalised care and support. For example, some people's families had completed a document called 'knowing me' but this information had not then been used to develop personalised plans to keep

people occupied and stimulated. In addition, the 'knowing me' documents had not been completed for everyone.
● There were activities staff employed and there was a programme of group activities. Although people were seen to be having fun whilst participating in planned group activities, people spent extended periods of time unoccupied at other times of the day.

Shortfalls in the planning and delivery of person-centred care was a breach of Regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the provider reviewed the assessments and care plans of those people with the highest and most complex needs. They sent us a report of the reviews and the subsequent action plans as required by the provider's condition of registration. The reviews completed showed there were multiple shortfalls in people's care plans. However, there were actions identified to address these to ensure people's care plans would accurately reflect their needs and so staff could deliver the care and treatment they needed.

Improving care quality in response to complaints or concerns
● People and relatives knew how to complain. Complaints information was displayed.
● Complaints were investigated but some complainants told us they were not always satisfied with the responses. Not all complaints were investigated in line with the provider's procedures. In addition, actions agreed in feedback to complainants were not consistently implemented. For example, a visitor told us they had made a formal complaint. However, they had not received a full written response from the registered manager in line with the provider's policy. The complaint records in the service gave contradictory information and included a meeting had taken place. However, the complainant informed us they had not attended a meeting with the registered manager.
● Complaints were not consistently reviewed by the provider to ensure that appropriate actions were taken in response. For example, one complaint included safeguarding concerns that had not been raised with the local safeguarding team.

Shortfalls in the monitoring of complaints was a breach of Regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the provider implemented robust complaints monitoring and review systems to ensure actions were taken in response to previous complaints and their policies were followed. We have not yet been able to test the effectiveness of this and we will review this at the next inspection.

End of life care and support
● People had been able to remain at the service for the end of their lives and staff had supported them according to their expressed wishes.
● Staff had worked with external healthcare professionals to ensure people had appropriate medicines so that their comfort was maintained.
● Compliments had been received and relatives had praised the care their loves ones had received at the end of their lives.

Requires Improvement

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 remained the same.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

At our last inspection there were shortfalls in the record keeping and governance at the service. This was an ongoing 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. The service had not met this regulation since the inspection in April 2017.

In March 2018 CQC imposed a condition of registration that every month the provider must carry out audits of people's care and risk management plans and send CQC a report of any actions required. The monthly action plans sent to us did not cover the requirements of the condition of registration.

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

- The provider's quality assurance processes were not fully effective and had not identified the multiple shortfalls found at this inspection. The governance systems had not driven improvements in the safety and quality of the service people received.
- The registered manager's lack of oversight of the service had resulted in the service not being safe and people being at risk of not receiving good quality care and treatment. For example people were not safeguarded from harm. The actions put in place had not protected people.
- People did not receive safe and good quality care. The shortfalls in the staff's skills and knowledge meant staff were not able to meet the needs of people with complex needs.
- People's care was not fully assessed and planned for in a person centred way that met their preferences and needs. This meant people did not always receive the support they needed to meet their care, welfare and well being needs.
- Staff recruitment was not always safe because of a lack of information about agency staff living in the home and shortfalls in the follow up of references.
- Complaints were not fully investigated and agreed actions were not always implemented.
- Records were not accurately maintained or effective. For example, people's care plan reviews were not effective and did not accurately reflect people's needs. Staffing rotas did not include which agency staff had worked so there was oversight as to whether the staffing needs of the service were being maintained. Some

of the documents used to record night time checks on people were pre printed with times on. These records were not accurate as they did not record the actual time people were checked and showed all the people who were checked at the same time.

The shortfalls in assessing and monitoring the quality of the service, and in record keeping were a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. Following the registered manager leaving the service during the inspection, the provider immediately ensured there was enough management cover in the service to oversee the safety and quality of the service. Actions were also taken in response to safeguarding concerns and additional staffing was provided to reduce the risks to people living at the home. The provider told us staff were being re-issued with key policies such as safeguarding and whistle blowing.

The provider was in the process of introducing new quality assurance and governance tools. There had been early indicators and the new systems had identified and flagged new risk areas at the service for the six weeks prior to our inspection. The provider's quality team told us they had planned to bring forward an internal inspection and full audit within the next month. However, we inspected the service before they were able to undertake these actions. The information the quality team sent us clearly showed there were some significant changes in incidents, accidents, complaints and alerts in the six weeks prior to the inspection.

The provider also decided not to admit any further people into the service until they had taken actions to address the shortfalls identified and ensure they could safely meet the needs of the people currently living at the service.

The provider implemented a plan to meet the condition of registration relating to the reviewing of people's care and risks they faced and committed to providing an action plan of how they planned to meet the shortfalls identified during the inspection.

The provider also sent us a plan following the inspection that included actions to meet all the shortfalls we found but also further shortfalls they had identified. The provider was also working proactively with the funding authority's quality improvement team.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people;
- Visitors and staff gave mixed feedback about how well-led the service was.
- Some staff spoke positively about the culture and management style of the registered manager and said they were very well supported and listened to. However, we also received contradictory feedback from other staff. They told us about a culture of where there was a division in staff and how they felt they were not treated fairly by the registered manager. Staff shared with us concerns about how the service had been managed and about the conduct of the registered manager.

The provider acted swiftly in ensuring the staff team was supported following the departure of the registered manager. This included representatives of the provider being based at the service to provide leadership and support the staff team.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
- The registered manager had held regular staff meetings and sent all staff a monthly summary of events

that had happened at the service. This included what the service had done well and things they needed to improve on.

● A daily 10 am meeting had also been introduced where key staff met with the registered manager to discuss the day's plan and any people who had been identified at risk

● Daily handovers were held by the nurses leading the shift on each floor, who ensured the care staff were made aware of any issues to follow up.

● The provider wrote to people, staff and relatives and held separate meetings with them following the departure of the registered manager. This was to inform people, relatives and staff of the changes and the management cover arrangements in place.

Working in partnership with others

● Health professionals told us the service made appropriate referrals for people and worked well with them. They said staff followed their guidance and advice.

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 9 HSCA RA Regulations 2014 Person-centred care There were shortfalls the assessment, planning and delivery of person-centred care to people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The systems in place for reviewing, recording and acting on complaints were not fully effective.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed There were shortfalls in the recruitment information about the suitability agency staff and the systems for ensuring the suitability of staff.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The shortfalls in staffing, induction, staff training and staff skills and knowledge to be able to safely care for people.

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 There were shortfalls in the assessments and management of risks for people.

The enforcement action we took:

.We have imposed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The service failed to protect people from abuse

The enforcement action we took:

.We have imposed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were shortfalls in assessing and monitoring the quality and safety of the service and in record keeping.

The enforcement action we took:

.We have imposed a condition on the provider's registration..