Coate Water Care Company Limited

Downs View Care Centre

Inspection report

Badbury
Swindon
Wiltshire
SN4 0EU

Tel: 01793740240
Website: www.coatewatercare.co.uk

Date of inspection visit:
21 January 2022
01 February 2022

Date of publication:
30 May 2022

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Downs View Care Centre is a residential care home registered to provide accommodation and personal care to older people. At the time of the inspection 38 people were using the service. Downs View Care Centre can support up to 51 people.

People's experience of using this service and what we found

Risks to people's safety had not been well managed. A range of risks to people had not been properly assessed or managed. Opportunities to learn from events had been missed and people's health needs had not always been followed up.

Medicines were not well managed. Medicines administered 'when required' (PRN) protocols lacked person-centred detail on when the medicine should be administered.

Infection prevention control measures were not always embedded and required improvement. PPE was not consistently used appropriately.

Staff training and induction was not adequate to provide staff with the guidance and skills to safely carry out their roles. Some people lived with diabetes, no staff had undertaken diabetes training.

Records were not kept to show how decisions were made in people's best interest. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

There was insufficient oversight of the service by the provider to pick up and address the risks found by inspectors. Records and communication with other professionals were an area of concern across the service. Information from healthcare professionals was not always recorded and followed up by the service. The provider had failed to make improvements and the service had declined in quality.

People and relatives told us the food was good and met their needs. Mealtimes continued to be a social occasion where most people ate at dining room tables and had the opportunity to interact with staff and chat together.

Staff were recruited safely. Disclosure and Barring Service (DBS) criminal record checks were completed as well as reference checks.

Following our inspection the registered manager stepped down and left the service. The provider

introduced a voluntary admissions embargo in order to focus on overall improvement of the service. They produced an action plan on how they plan to address issues raised during this inspection and shared this with us.

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 20 August 2021). Two breaches of regulations were found in relation to safe care and treatment and good governance. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This inspection was also prompted by our data insight that assesses potential risks at services, concerns in relation to aspects of care provision and previous ratings.

The inspection was also prompted in part due to concerns received from other healthcare professionals about people's safety and lack of communication with the service. A decision was made for us to inspect and examine those risks. We undertook a focused inspection to review all the key questions review the key questions of Safe, Effective, Responsive and Well-led only. This enabled us to review the previous ratings.

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 report. Please see the Safe, Effective, Responsive and Well-led sections of this full report.

The overall rating for the service has changed from Requires Improvement to Inadequate. This is based on the findings at this inspection.

Enforcement and Recommendations
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 monitor the service and will take further action if needed.

We have identified six breaches in relation to person-centred care, need for consent, safe care and treatment, good governance, staffing and notification of incidents at this inspection.

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

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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Downs View Care Centre

Detailed findings

Background to this inspection

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

As part of this inspection we looked at the infection control and prevention measures in place. This included checking the provider was meeting COVID-19 vaccination requirements. 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
On 21 January 2022 two inspectors, an inspection manager and an Expert by Experience began the inspection. The Expert by Experience spoke with people and relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. On 1 February 2022 two inspectors and an inspection manager returned to continue the inspection of the service.

Service and service type
Downs View Care Centre 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.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority who commission the service. We used all of this

information to plan our inspection.

During the inspection
We spoke with four people who used the service and six people's relatives about their experience of the care provided. We spoke with 10 members of staff including the quality manager, the operations director, the nominated individual, registered manager, administrator and six care staff.

We reviewed a range of records. This included six people's care records and multiple medication records. We looked at three staff files in relation to their recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed. 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 continued to review records and seek clarification from the provider to validate evidence found. We looked at training data, supervision records and other documents supplied by the provider.

Inadequate

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12(1) 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

● People's medical conditions were not managed safely. For example, care records stated that two people had Type II diabetes. However, the service stopped their diabetic diet. One person had been hospitalised due to hyperglycaemia during the time they were not receiving a diabetic diet. One person's records, completed by their GP stated, 'Deterioration in condition and deterioration in Type II diabetes which can lead to weight loss.' We saw records confirming significant weight loss of this person. No referral had been made in respect of the weight loss and none of the healthcare professionals we spoke to were aware that the specialist diabetic diet had ceased. Another person had their blood sugar monitored regularly, we saw two occasions in December where their blood sugar reading had been at an unsafe level, but health professionals had not been consulted in line with their care plan.
● Risks associated with people's individual care needs and the impact of their health conditions had not been fully assessed. Care plans lacked guidance to enable staff to meet people's needs safely. For example, some people did not have oral health care plans on the first day of the inspection.
● People's skin integrity was at risk of deteriorating due to poor oversight of care in this area. Staff and the registered manager were not always aware of which people had pressure damage to their skin and needed to see a health professional. For example, a district nurse visiting on the first day of inspection was not aware of one person's pressure wound until the CQC inspectors told her. Staff did not mention this to the district nurse as she was about to leave the service. When the district nurse attended to the person, they found a dressing was required. Care plans did not give specific guidance to staff on how often people should be repositioned to avoid pressure damage.

The provider failed to ensure care and treatment was always provided in a safe way. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

At our last inspection the provider had failed to ensure safe management of medicines. This was a breach of regulation 12(1) 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

● Medicines were not always stored securely. On the first day of our inspection we observed a member of staff, responsible for medicines, left a medicines trolley open in an unlocked room, which was visible and accessible to people living in the service. There was a risk that people living with dementia could access medicines which were not prescribed to them. The staff member continued to leave the medicines unlocked after the inspector pointed out the risk. The registered manager was made aware of this and took action to manage the risk. A new member of staff continued administering medicines safely. The medicines were administered safely during the second day of our inspection.
● Topical creams were not stored securely. During the first day of our inspection we observed topical creams were easily accessible to people who were not authorised to have access to them. This presented a risk to people living with dementia. We raised these concerns with the registered manager and provider.
● On the second day of the inspection we saw that most of the topical creams were stored in transparent plastic boxes. However, not all the plastic boxes had their lids closed, so anyone could obtain unauthorised access to the topical creams. We saw no evidence that this method of storage had been risk assessed. Some topical creams were still left out on surfaces in people's rooms and we observed a prescribed topical cream left out in a corridor accessible to all.
● The topical creams were not always managed well. We found creams were not always dated when opened in line with the provider's procedure. This meant the quality of the topical creams could be compromised.
● Protocols were available to guide staff on when it would be appropriate to administer medicines which were prescribed to be taken 'when required'. However, they lacked clarity on when the medicine should be administered. For example, one person's PRN protocol stated they were to take their medicines daily as needed. When asked about their understanding of the instruction, a member of staff said it meant to administer daily. This posed a risk of people being overmedicated due to the lack of clear PRN protocols.
● PRN protocols were not always up to date. On the first day of the inspection the electronic medication system (e-MAR) showed that 34 PRN protocols required to be updated. On the second day of the inspection 18 PRN protocols still required an update.
● We could not be sure that people had their prescribed creams applied in line with the prescription. Topical medicine administration records were not completed when cream was applied. We observed staff retrospectively signing records for the day prior to inspection and they were not able to confirm if the cream had been applied or not.

The provider had not ensured people's medicines were managed and administered safely. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● Infection prevention and control measures were not always followed by staff in line with the government requirements to manage the COVID-19 pandemic.
● We were not assured the provider was preventing visitors from catching and spreading infections. Not all checks on visitors entering the building were undertaken. For example, inspectors were not all asked to show confirmation of a negative COVID-19 test and inspectors were not asked to show confirmation of their COVID vaccination status in line with recent changes to regulation.
● Staff were not always using PPE (personal protective equipment) effectively and safely. On the second day

of the inspection we observed two members of staff changed their gloves, but not their aprons between delivering personal care to people. This is not in line with government guidance on using PPE in care homes.
● We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed. At the time of our inspection the service was experiencing an outbreak of diarrhoea and vomiting. We observed the same sling hoist being use for two different people consecutively. This presented a risk of cross infection. When we raised this staff they took action to find a second clean sling to place in one of the bedrooms.
● We were not assured that the provider's infection prevention and control policy was up to date.
● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. Whilst there was an ongoing maintenance programme being undertaken at the home, there were areas of the home which presented an infection control risk and required refurbishment, such as some bedroom carpets, bathroom floors and walls.

The provider had failed to mitigate risk in relation to infection, prevent and control. This placed people at risk of infection. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection the provider sent us an action plan outlining the improvements they planned to make.

● We were assured that the provider was meeting shielding and social distancing rules.
● 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 have also signposted the provider to resources to develop their approach.

From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency. We checked to make sure the service was meeting this requirement. We found the service did not have effective measures in place to make sure this requirement was being met.
● On both days of our inspection the provider failed to ensure that the inspection team was fully vaccinated against COVID-19.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Most people and relatives told us there were not enough staff to meet people's needs. One person's relative told us, "Sometimes she doesn't have water when we visit. Staffing seems quite low. Sometimes it would seem there are only a couple of them on." Another person's relative told us, "Staff seem very busy, perhaps they are understaffed? There is not much time to talk. They don't have conversation much when I am there, but they keep me updated."
● Staff told us there were not enough of them to meet people's needs. A member of staff told us, "I like it here but not always fully staffed." Another member of staff told us, "We have a lot of people who need assistance with drinking, we need to stay with them". We asked if they have enough staff to do this. The member of staff replied "No".
● Before our inspection we received an information of concern regarding low staffing numbers at the service. The provider used a tool to calculate their staffing numbers, however, during the first day of the

inspection we observed there were not enough staff to meet people's needs. At the beginning of the first day of inspection there were less staff than the number of staff required by the dependency tool used by the provider. There were not enough staff to support people to eat, drink and reposition them regularly. Night staff stayed on shift until 12PM to ensure people had the necessary support to eat breakfast and get up. Later in the day we observed the required number of staff were on duty. However staff appeared rushed and there were still not enough staff to support all the people who needed support with eating in a timely way at lunch and people were not being supported to reposition regularly to maintain their skin integrity.
● We raised our concerns about the staffing levels with the provider on the first day of our inspection. On the second day of our inspection the provider told us they planned to increase the number of staff working during the day to improve the quality of care. Whilst there were more staff on duty, we observed staff were not always effectively deployed. There was a lack of clear leadership on the floor which meant staff did not always know what they were doing and were worried about who would be doing what. For example, a member of staff who was still assisting people with personal care at 11.30AM was worried that no one would be doing a morning tea round and people might not be supported to drink enough.

This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● It was not clear if lessons were always learnt when incidents happened. Not all incidents were recorded within the home and they were not always investigated. We looked at the electronic incident recording system. Incidents which had been recorded had not been submitted for review. This meant opportunities to learn lessons and improve practice were missed.

This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● On the first day of the inspection we raised with the provider number of issues relating to safe care and treatment and overall governance of the service. On the second day of the inspection, 11 days later, we saw some areas of practice in relation to infection control, COVID-19 and safe storage of medicines remained unsafe. For example, on both days of the inspection inspectors were not asked to show confirmation of a negative COVID-19, their COVID vaccination status and their temperature has not been recorded.

Systems and processes to safeguard people from the risk of abuse
● People were being cared for by staff who had undertaken training in safeguarding procedures. However, staff did not always demonstrate awareness of safeguarding and whistle-blowing procedures and were unable to describe how to safeguard vulnerable people. One staff member told us, "If I saw a staff member behaving in a bad way, I would challenge it with them. If it carried on, I would report it." The member of staff told us they never had to report any safeguarding concerns but had seen bad practice at the service. This showed a lack of safeguarding awareness amongst the members of staff.
● The provider told us about some of the difficulties they had experienced in the sharing of information with external safeguarding bodies. The provider had taken steps to try and improve the two-way process of information sharing with external bodies, to ensure timely action could be taken to protect people. At the time of our inspection improvements were still required and we found safeguarding concerns which had not been acted upon in a timely manner to protect people.
● People and their relatives told us they felt people who used to service were safe. One person told us, "I am being looked after so am still going. I think I would be dead if not." One person's relative told us, "I feel he is safe and ok."

Requires Improvement

Is the service effective?

Our findings

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

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

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

- People's physical and mental health and social needs were not holistically assessed. For example, care plans did not contain records of oral health assessments, people's social needs or health needs for people with diabetes. As a result, care and treatment was not always delivered in line with national guidance and best practice. For example, diabetic care plans did not always follow best practice guidance. Instead people's diabetic care plans instructed staff to fortify their diet with sugars. There was no evidence of annual diabetic reviews taking place for people living with diabetes.
- People did not have their oral health supported in line with national guidance and best practice. Most people did not have toothbrushes and toothpaste in the bathrooms we looked in on the first day of our inspection and most care records we looked at did not contain an oral health care plan. By the second day of our inspection the provider had purchased toothpaste and toothbrushes for people and oral health care plans had been created.
- During our inspection we found that some people were lying on their beds with no bed linen just on bare plastic mattresses.

People's needs were not fully assessed and care was not designed and delivered to meet people's needs. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities).

Staff support: induction, training, skills and experience

- During our inspection we observed agency staff were being used. Agency staff told us, and we observed, they had not received a comprehensive induction when they started work and did not have access to any records detailing what people's needs were. There was a risk that agency staff would not be equipped with the necessary information and knowledge to do their job safely and effectively.
- Staff did not always receive training to meet the specific needs of people. For example, diabetes awareness, mental health, behaviours that challenge or pressure ulcers prevention training. We spoke with staff about their confidence and training in relation to supporting people with advanced dementia and the behaviours associated with dementia. A member of staff told us, "I had not received any specific training around behaviours that challenge. [Person] takes other people's food and there are not enough staff to monitor this."
- We received mixed feedback from staff regarding the supervision and support they received from the provider. Some staff could not recall when they received their last supervision. We asked the provider for records of supervision for three members of staff. The provider was unable to locate them and provide us

with them within a set timeframe.

Staff had not always received appropriate training and support putting people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities).

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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the 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.
● Significant decisions had been made in relation to people's care and treatment without evidence of the MCA and best interest decision making process being followed. For example, there were no records of capacity assessments or best interest decisions in relation to the decisions to stop giving a diabetic diet to two people who were diabetic.
● One person told us they would like to go out to town, however, they were always being told there were not enough staff to accompany them. The person's care plan indicated a DoLS application had been made and the assessment was awaited. We asked the registered manager if the person had a DoLS assessment in place. The registered manager told us they thought it had been completed, however, they did not have a copy of the DoLS assessment and were not able to confirm what the conditions were. Following our inspection, the provider obtained a copy of the DoLS assessment, which had been completed in December 2021 and stated this person had six conditions in place. The provider did not meet these conditions at the time of the inspection. This meant the provider failed to act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.

This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities).

Supporting people to eat and drink enough to maintain a balanced diet
● We received positive feedback from people and their relatives regarding the quality of food. One person told us, "I eat in the dining room, we have wonderful meals. There is a choice to an extent, but I very much like the food." Another person's relative told us, "Meals look good, I have seen her eat. She eats independently."
● During our inspection we saw that people were offered a choice of food and staff assisted people appropriately. However, as highlighted in the safe domain of this report, people did not always receive a diet which met their health needs.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● The system of communication between staff and external health professionals needed to improve to

ensure people received consistent, effective and timely care. For example, important information regarding people's skin integrity from the district nursing team was not being handed over between staff in the service, or effectively recorded to ensure people received the right care. This posed a risk of further deterioration of pressure sores.

● Improvements were required to ensure all the necessary health professionals were consulted and involved in making decisions around people's care and support. For example, there was no record of the GP, dietician, or district nursing team being involved in making decisions around care for people living with diabetes and we were concerned this meant people were not being supported to live healthy lives.

This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities).

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

● We observed a number of rooms used by people to be very empty with bare walls and limited furnishings.

● The provider was in process of re-decorating the service to create a more dementia – friendly environment. The structural design of the home was accessible for people using wheelchairs and enabled people to freely move around at their leisure.

● There was a dementia-friendly garden area for people to use at their leisure.

● The dining areas were designed to encourage social interaction. For example, dining tables were small to encourage conversations at mealtimes.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question requires improvement. The rating for this key question has remained 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; 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

● Some PRN protocols were not person-centred and failed to provide staff with an appropriate instruction to follow. One person's PRN protocol stated their behavioural PRN was to be administered when needed before leg dressings. However, there were no clear instructions for staff as when to administer the PRN. There was no information about potential triggers, or the type of support needed by the person. On the first day of the inspection we saw this person had their dressing changed, however, staff struggled to calm them down. Staff were trying to guide the person into their bedroom with touch support, but the person was holding against the doorframe preventing staff from leading them there. It took staff some time to calm the person down and their dressing was not changed in their room but in the conservatory. The PRN had not been administered. On the second day of the inspection we saw that the person had their dressing changed a day before. Again, behavioural PRN had not been administered. We checked the records and the PRN had never been administered since it had been prescribed. This proved the lack of person-centred care planning as there were no clear instructions for staff as when to administer the PRN.

● People's care plans lacked personal information about people's backgrounds, events and persons important to people. One person's care plan referred to another person's name. Care was not designed with a view to achieving service users' preferences and ensuring their needs were met.

● On the first day of the inspection we saw that one person spent the entire time of the inspection in a chair in the lounge. The person's bedroom was full of another person's belongings, due to the other person's room being redecorated. The person could not return to their bedroom if they wished so.

● There was a lack of meaningful activities organised for people living at Downs View Care Centre. Staff told us that low staffing levels did not allow them to organise any meaningful activities. On the first day of the inspection we saw that a member of staff was taking magazines around to people and trying to engage some of them in reading. However, people could not comprehend that activity due their advanced dementia. The TV in the Montgomery unit was not working during the first day of the inspection and for the most of the second day of the inspection. We were told by staff that the TV had not worked for some time and this had been raised with management. A member of staff told us, "People used to bake, cook, make flowers but not recently. It is difficult to support people in this area with so few staff." The lack of meaningful activities meant people were not receiving care that was appropriate, met their needs and reflected their preferences.

● One person's care plan stated that the person would eat their meals either in their room or in the lounge, depending on where they were seated at that time. However, during our inspection we saw that the person was deprived of having meals in the lounge and was led to their own room by a member of staff. Staff told us that the person ate their meals in their room as otherwise they would attempt to take other people's food

and drinks. On the first date of our inspection we entered the person's room whilst they were eating their breakfast. There was no table for the person's plate and their plate was placed on the chest of drawers which was not within the reach of their chair. There was half a sausage on the floor along with other food debris, and we could clearly observe the person's mouth was full of sausage. This means that the person did not receive care that was appropriate or reflected their preferences.

People's needs were not fully assessed and care was not designed and delivered to meet people's needs. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities).

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.
● Some care plans included information on how people liked to communicate with others. However, other care plans contained no information on how to communicate with people with advanced dementia.

Improving care quality in response to complaints or concerns
● There was a complaints policy in place and formal complaints were recorded, investigated and responded to appropriately, however relatives told us the informal concerns they had raised had not been responded to.
● Most of the people and their relatives told us they felt confident in raising complaints with the registered manager. One person told us, "If there was an issue I could go straight to lady in charge. They help a lot. I can go and explain what is happening and they will do something about it."

End of life care and support
● None of the people currently living at the home required support with end-of-life care at the time of the inspection.
● Care plans were in place which reflected peoples wishes and people they would like to be involved at the end of their life.

Inadequate

Is the service well-led?

Our findings

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

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

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

At our last inspection the provider's quality auditing systems did not always highlight the concerns we found at inspection. This had not improved at this inspection. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Measures to monitor the quality of the care provided were not always effective, this meant that the registered manager did not have a full oversight of issues at the service to drive improvements. The continuing improvement plan submitted by the registered manager prior to our inspection visit identified actions as completed. However, during the inspection we found these had not been carried out as stated. For example, actions relating to the management of medicines or staff training had been signed off as completed, however, during our inspection we found many issues relating to the management of medicines and staff competencies to administer them.
● The system to record and investigate incidents and accidents was not used effectively. Three accidents had been recorded on the electronic system (PCS) since November 2021, all three relating to falls involving residents. None of the PCS accident forms had been fully completed or submitted for review. On PCS there had been three falls recorded in December and eight falls recorded in January. The report from the registered manager to the provider in December 2021 only noted two falls, when in fact there had been three in the service during the month of December.
● On the second day of the inspection we started inspecting at 6am, however, we could not access the PCS system until 9am. Staff Member 10 told us the system had been offline since the evening of the day before. This meant there was a risk of break in continuity in care records.
● There were no effective systems or processes in place to ensure the records of peoples' needs and risks reflected their current care needs. Some records were inaccessible, inaccurate, and could potentially put people at risk of harm.

Systems and processes to monitor the quality of care and monitor staff were not always effective. This placed people at risk of harm. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection visit the registered manager stepped down and the provider immediately appointed an experienced manager to help make the required improvements. The provider sent a new

action plan involving a voluntarily imposed embargo to prevent new admissions until necessary improvements have been introduced and embedded within the service. We will continue to monitor this to assess the impact on people at the next inspection of the service.

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

● People's records were not stored confidentially; on the second day we saw the office on Montgomery unit was left unlocked so anyone could access confidential information such as letters from professionals or old care folders.

● Staff were not working as effective teams, ensuring that mistakes in practice were identified quickly and confidently brought to the attention of their colleagues or members of the management team where required.

● On the first day of the inspection we saw 'It's Christmas Day' written on a board in the Montgomery lounge. We brought this to the attention of the registered manager. They took no action to correct it and on the second day of the inspection the board still displayed that message. On the second day of the inspection in the other unit information on the wall said it was 'Friday' when it was actually Tuesday.

● We found that although effective management systems were lacking, there was a positive culture amongst staff.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● During our previous inspection in July 2021 we found that the registered manager had not always notified the CQC about significant events which they are legally required to do so. During this inspection we found that this issue remained unaddressed and we not always received notifications from the provider. For example, we were not notified about a fall that resulted in a head injury and an open wound.

This was a breach of Regulation 18 CQC (Registration) Regulations 2009.

● The registered manager and the nominated individual were open and honest during the inspection as to what improvement was still required at the home.

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

● People and their relatives told us they felt involved in running of the service, however, their involvement was affected by poor communication with the service. One person's relative told us, "There is a poor communication with the service. No response to emails, they promise to ring back and don't." Another person's relative told us, "Their communication is rubbish. Only three emails since [person] has been there. All general not personal. [Person] has had to go to hospital. Then she had COVID-19 and they did not tell me."

● We received mixed feedback from staff regarding their morale and how it impacts on quality of the service provided to people. A member of staff told us, "During one of the meetings we also discussed low staff morale; staff saying they don't want to come to work." Another member of staff told us, "We're not a team when it comes to working on shifts."

● Improvements to working relationships with external professionals were required to ensure positive outcomes for the people using the service.

Working in partnership with others; Continuous learning and improving care

● Healthcare professionals told us that communication with service was very poor. One healthcare

professional told us that the service was reactive rather than proactive and did not always follow professional advice. Another healthcare professional told us they had raised their concerns with a unit leader and with an agency staff member working at the service. However, that information was not passed to the registered manager and there were no records of the healthcare professional's feedback. Neither was there any evidence of any action undertaken to address the feedback received. This means that systems and processes were not effective in respect of ensuring people's needs were known about.

● We discussed this with the provider who agreed to look for ways to improve the communication to ensure staff received the correct instructions to follow and this was updated in the care plan.

● We could not see whether the service was committed to continuous learning and improving care. The overall quality of care had declined since our last 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 18 Registration Regulations 2009 Notifications of other incidents The provider failed to notify the Commission without delay of the incidents which occur whilst services are being provided in the carrying on of a regulated activity, or as a consequence of the carrying on of a regulated activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure that sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet people's needs.

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 9 HSCA RA Regulations 2014 Person-centred care The provider failed to do everything reasonably practicable to make sure that people who use the service receive person-centred care and treatment that is appropriate, meets their needs and reflects their personal preferences, whatever they might be.

The enforcement action we took:

Notice of Proposal to impose conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure that care and treatment of service users is provided with the consent of the relevant person. The provider failed to act in accordance with the 2005 Act.

The enforcement action we took:

Notice of Proposal to impose conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to assess the risks to the health and safety of service users of receiving the care or treatment; do all that is reasonably practicable to mitigate any such risks;

The enforcement action we took:

Notice of Proposal to impose conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to establish and operate

effectively systems or processes to ensure compliance with the requirements of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
The provider failed to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity.
The provider failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.
The provider failed to maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;

The enforcement action we took:

Notice of Proposal to impose conditions