Quantum Care Limited

Providence Court

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Providence Court is a residential care home providing personal to up to 61 people. The service provides support to older people, some of whom are living with dementia, in one adapted building. At the time of our inspection there were 51 people using the service.

People's experience of using this service and what we found
People's safety was not always well managed. Infection control practices were not followed effectively even though the staff knew what they needed to do. This was in relation to cleaning regimes, handwashing and face mask wearing. Some carpets and chairs needed to be cleaned as they were grubby, and paintwork was chipped making cleaning more difficult. The home was in a COVID-19 outbreak at the time of inspection and the management team were not sure about the numbers of people Covid-19 positive in the home, or which units were affected. However, most staff did know who had tested positive.

Staff did not have prompt access to people's individual needs and risks due to a shortage of handheld devices which gave them access to this information. Insufficient action had been taken to get these issues resolved. Changes to people's health needs were not always recognised by staff and appropriate action was not always taken. We found several examples of relatives needing to prompt medical intervention.

Pressure relieving equipment to help support people's skin integrity, was not always checked by staff to ensure it was set correctly. People's needs were not always met in a timely way by staff to reduce risks. Medicines were not always managed safely. People had to wait too long for pain relieving medicines. People told us they felt safe and staff knew how to report concerns. However safeguarding risk management had not been followed in one instance.

People's dignity was not promoted. Staff left a door open with a person in full view of a communal area while using the toilet and staff spoke loudly about supporting people with care needs.

People, relatives and staff said there was not always enough staff to meet people's needs. People told us most staff were nice, but busy. We saw examples of people waiting for care needs and a member of the regional support team needed to step in to provide care. We also found that some staff training was not up to date or in place. For example, diabetes awareness. Some, but not all relatives were confident about the standard of care and told us staff were friendly.

People had access to food, drink and call bells throughout our inspection. However, while we saw that there were records kept of fluids consumed, for some people cared for in bed, we noted drinks did not change in quantity for most of the morning.

The management systems in the home were in place, however had not been effective to address the shortfalls found during this inspection. Feedback about the management was mixed, staff felt there was a

lack of support, guidance and leadership which had impacted on morale and culture in the home. People and relatives gave mixed views about how responsive management had been to concerns and leadership. The home had had four managers in the past year. The new manager started the day prior to the inspection and was on their induction.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and or who are autistic.

Rating at last inspection
The last rating for this service was good (published 6 June 2018).

Why we inspected
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 undertook a targeted inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received standards of care, response to changing health needs, management and staffing. A decision was made for us to inspect and examine those risks.

We inspected and found there was a concern with safe care and robust leaderships so we widened the scope of the inspection to become a comprehensive inspection which included the key questions of safe, effective, caring, responsive, and well-led.

The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see all sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Providence Court on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to safe care and treatment, safeguarding, dignity and respect, staffing and governance systems at this inspection.

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

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will 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 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Providence Court

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 was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors.

Service and service type
Providence Court is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Providence Court is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was not a registered manager in post. There was a new manager who had started the day prior to the inspection and the home was being supported by a regional manager.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from health and social care professionals. 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 used all this information to plan our inspection.

During the inspection
We visited the service location on 22 November 2022 and had a video call with the manager, regional manager, regional support manager and Head of Quality and Practice on 8 December 2022. We spoke with six people and eight relatives. We also spoke with 15 staff including the manager, deputy manager, regional manager, regional support manager and support workers. We received feedback from health and social care professionals.

We reviewed a range of records. This included eight people's care records and medication records. A variety of records relating to the management of the service were also reviewed. These included training records, incident records and quality assurance processes.

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.

What we did after the inspection
We sought assurance about records involving people's care and support needs and preferences.

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 good. 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; Using medicines safely

- There were mixed views from people and relatives as to whether they felt they, their family member were supported safely by staff. One person, who was mainly independent, said, "I feel so safe and well cared for here." A relative said, "I am happy with [person's] care now. We did have previous issues when the last manager was here, but it is all sorted now." However, they went on to tell us about things that gave us cause for concern about the management of risks.
- There were individual risk assessments in place for people and these were reviewed monthly. However, staff did not always have access to these records. There were limited handheld devices that gave staff access to people's information. When we asked staff about people's needs and risks, they were not always able to answer. For example, one person was crying in pain. A staff member had just administered a morphine-based medicine. We asked the staff member what the cause of the person's pain was and they did not know. A healthcare professional told us, "Carers are not familiar with the residents because they often rotate to different units. Often when I am asking then to give me some history of what the health concern is, I am told they are not sure as they were away, or they were on another unit. As you will be aware, many of the residents have dementia and this is vital information in assessing a resident."
- One person was experiencing pain and it was causing them distress. After their medicines, the person remained in pain, no other considerations had been made to ease the pain. We heard staff tell them to 'Shush' while crying from the pain during personal care. From a brief discussion with the person we were able to come up with three different ways that may help. We asked the person and staff, and all confirmed none of these had been tried. We asked staff when the person last had a medicines review. Staff were not aware and were unable to check as they did not all have access to care plans. The care plan stated the person's health condition and that they had pain medicines for this. There was no other instruction to guide staff.
- Care notes for this person stated they were 'content' throughout the whole period we observed them to be distressed and crying. No attempts to relieve the person's pain through anything other than pain medicines were noted over a period of a week we reviewed.
- Relatives told us, and we saw in records and through our observations, that changes to health were not always picked up. One relative said, "If [person] is poorly staff don't explore what is bothering them. Nothing is done unless I do it."
- People were recorded as being supported to change their position regularly. There was equipment in place to help prevent pressure ulcers developing. However, pressure care equipment was not always used effectively. For example, when people had pressure relieving mattresses, they were not always set to their weight. One person weighed 37.7kg but their mattress was set to 50-70kg. This put them at risk of developing a pressure ulcer or discomfort.
- Where people were at high risk of developing a pressure ulcer, repositioning and continence care was not

always carried out in a timely fashion. For example, one person was lying in a wet bed and we needed to raise this with a senior manager so they could assist them as other staff were not available. We reviewed the person's care notes and found there had been a gap of seven hours since continence care had been recorded as being last actioned. Gaps of upwards of six hours between these entries were frequent on the notes we reviewed.

● We reviewed medicines recorded and counted a random sample of medicine quantities. We found in most cases medicines were administered and recorded appropriately. However, we found for one person on a pain-relieving patch, this had been given a day late. In addition, records had not been amended to ensure that the new required date was reflected. We also saw that the body map used to identify the location of the patch had not been completed for the most recent administration. This is important because staff need to remove the previous patch before adding a new one. This also allows staff to check the patch remains in place to manage the person's pain effectively. Their care notes also stated the patch was not in place. No action was taken in relation to this to ensure the person was receiving the appropriate pain relief.

● People had access to their call bells or sensor mats were in place to help alert staff to their need for assistance. However, staff on one unit were very busy and call bells rang for quite some time before staff could answer them.

Preventing and controlling infection

● We were not assured that the provider was preventing visitors from catching and spreading infections. The cleaning regimes in the home and staff wearing masks inappropriately increased risk to visitors.

● We were not assured that the provider was supporting people living at the service to minimise the spread of infection. The home was in outbreak at the time of inspection. The management team were unclear how many people were positive for Covid-19 and what units were affected. Also, hand washing and alcohol gel stations were limited. Two alcohol hand gel dispensers we tried were empty.

● We were not assured that the provider was using PPE effectively and safely. Several staff repeatedly had their masks under their noses or chins, despite being reminded by inspectors.

● We were not assured that the provider was responding effectively to risks and signs of infection. While doors were closed for people testing positive, and some controls were in place, processes had become less robust than during the height of the pandemic. Staff were not always washing hands in between tasks.

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. High touch areas were not being cleaned as frequently as required. Medicines trolleys were not cleaned after use or before being stored in a room used by all units. Chlorine based cleaning products required for managing Covid-19 outbreaks were not being used at all times and cloths were used to clean large areas without being changed between areas.

● We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed. Staff were being shared across all units; staff moved between units including visiting the kitchen for trolleys. Staff all used the same break room and using the same doors and stairways to go in and out of the building.

● Following the inspection, the regional manager told us, "PPE training for remaining staff will be captured over the coming days according to when the individual staff are next on shift. Daily observations are being carried out by the senior team, spot checks carried out by myself today and further unannounced visits over the coming weeks are to take place."

Due to people's safety not being consistently promoted through safe care and the lack of safe infection prevention and control practices this was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● People were able to have friends and family visit them freely. Controls, such as wearing a mask, were in place for visitors. This meant they were able to support people with meals and visit people in communal areas, or in their rooms.
● People who were at risk of malnutrition were provided with fortified foods and drinks. Weights were monitored and concerns were reported to healthcare professionals.

Systems and processes to safeguard people from the risk of abuse
● The management team reported allegations of abuse to us and the local authority appropriately. However there had been a recent serious safeguarding allegation made. As a result, the local authority safeguarding authority had instructed the service on actions to be put into place to protect people from the risk of abuse and also ensure staff were also protected from further allegations. We found that instructions given by the safeguarding team had not been actioned. This meant people were at a continued risk of sustained harm.
● We also found that there was a recent medicines error that had not been reported appropriately.

Therefore, this was a breach of regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● People told us they felt safe living at the service.
● Staff were able to tell us how they would report concerns relating to risks of abuse. Training had been provided and information was displayed.

Staffing and recruitment
● People and relatives told us most staff were kind, but most people and relatives we spoke to were not sure there were enough staff available. One person told us, "I wanted my medicines at a different time I'd agreed with another carer. [Staff member] told me I had to have them, when I said I didn't have to they went off in a huff. Maybe they were busy. I didn't get them at the time I wanted in the end so went without." We reviewed the medicines record, and this had been recorded as refused. A relative told us, "Some care workers are very good but there seems to be a shortage of staff and this means they leave my [person] in bed."
● We observed the staff member they mentioned and raised their practice with the management team as a staff member needing further development. At 9.30am another person, who was trying to get someone to come and support them, said, "I like to get up earlier than this really, but they are busy." We saw the person at 11.30am having their breakfast.
● Staff told us staffing at the home varied depending on if they were working with agency staff. One staff member said, "We don't have enough staff." On one unit we saw staff were extremely busy and this made care task led instead of being personalised to people's needs.
● Health professionals also told us they did not feel there were enough staff. One health professional said, "I feel the home is inadequately staffed for the number of residents they have, particularly those with dementia who have greater care needs and require more 1:1 time." We raised this with the management team.
● We also found that while training had been completed in many of the key areas, such as moving and handling, dementia awareness, infection control and fire safety, some staff were overdue for refreshers. We found staff had not been trained in some health conditions, such as diabetes, even though there were a number of people living at the service with diabetes.

Due to people needing to wait for support and staff skills and knowledge not being consistently updated or in place to ensure people's safety, this was a breach of regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● Following our feedback the regional manager told us, "Having reviewed residents needs and dependencies, staffing has been raised to four care staff during the core parts of the day, in addition, [unit in outbreak] has been allocated an additional staff member to support the team during the outbreak. Staffing levels will remain under review and will be flexed according to residents changing needs."

Learning lessons when things go wrong

● The management team told us they reviewed events and incidents to see if there was any learning to take from them as part of their monitoring of events in the home. However, due to our findings as part of our inspection, this did not give us assurances that trends and themes would always be identified, and that the provider would be able to take actions following learning from events that happened.

● We saw some feedback to staff in meeting notes about events in the home and how to help reduce these going forward.

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.

Staff support: induction, training, skills and experience

- People and their relatives gave mixed views about if staff were well trained and knowledgeable for their role. However, one relative said, "The senior (staff) are really brilliant. My [person] can be very awkward and stubborn, but they have patience with them."
- Staff received training in many areas relevant to their role. This included moving and handling, safeguarding people from abuse, health and safety and first aid. However, in many cases, the updates to this training was overdue. We also found that training in key subjects such as diabetes had not been provided. In addition, the service supported two people with a learning disability. However, training for staff had not been provided for this. The provider told us this was planned.
- Staff had not received regular supervision to help ensure that they had a clear understanding of their role or ensure they felt supported. The lack of supervision also meant manager's did not ensure they were working in accordance with regulations. Several staff told us they felt unsupported by the provider and the recent managers in the home.

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

- People and their relatives said staff supported them with eating and drinking. One relative said, "They are very poorly and frail at the moment, but they (staff) keep encouraging them to eat and drink." We observed people be offered visual choices for their meal to help them decide.
- People's dietary needs and preferences were documented in their care plans. People's weight records showed that if people were losing weight, a plan was in place on how to support them to improve their intake. There was an overview of people's risk levels and the kitchen team had a national plan to follow.
- While drinks and snacks were placed around the unit, we did not see these offered to people, especially those cared for in bed. On one unit, half an hour before lunch, one person was saying they were hungry. Rather than offering a snack to tide them over, a staff member told the person, "You are always hungry." Following our observation, a snack was offered by the staff member.

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

- People's needs were assessed before they moved into the home. Assessments included people's individual needs, risks and preferences. However, the service also took in a high number of emergency admissions, so they relied on external assessments in this case. A health professional told us they felt they were not always prepared for some complex care that arose after people had moved in so felt the assessment process may need to be more robust.
- However, even though concerns were noted and had been raised, people and their relatives told us they

felt the service was able to meet their needs. One relative said, "Staff seem to be looking after [person] really well."
● There were monthly reviews of people's needs. These were discussed at regular meetings. However, it seemed that these meetings were for senior staff and the information did not always get passed to all care staff. We asked care staff about people's needs and they were not always able to tell us.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People had access to health or social care professionals as needed. At times, this was prompted by relatives' requests. While we were told by relatives and health professionals that senior staff were able to identify changes, due to ineffective communication through the teams, and care staff not being empowered to recognise changes, the senior staff were not always aware of the changes. One relative said, "If [person] is poorly staff don't explore what is bothering them. Nothing is done unless I do it." However, another relative said, "Staff notice if [person] is a bit off colour and they monitor food and fluid intake and [person's] weight regularly."
● Staff did not always respond if a person became unwell or needed additional support. Relatives often made the request for health care support. We also identified health issues that staff needed to follow up with a health professional.
● When staff did contact visiting health professionals, their advice was followed. However, professionals told us the lack of information about new people moving into the home, or information about people's needs available from staff needed to be improved.

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. We checked whether the service was working within the principles of the MCA.
In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty safeguards (DoLS).

We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

● People and relatives told us that staff asked for consent when supporting them. We observed staff asking people before supporting them on the day of inspection.
● People had mental capacity assessments completed in most cases. The assessments reflected where a best interest decision had been made. Assessments detailed people's responses to questions and stated if a relative had been involved in the process.
● Staff received training in the Mental Capacity Act.
● Where a DoLS application had been made, a tracker was in place to monitor its progress.

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

Respecting and promoting people's privacy, dignity and independence; Ensuring people are well treated and supported; respecting equality and diversity

- All bedroom doors were open when people were in bed or sitting in their chair. It was not clear in care plans if this was preference or to enable staff to check on people.
- Staff referred to people as 'darling' and 'love' rather than people's names. This was not their preferred term. There was a lack of engagement from staff when supporting people with care tasks.
- We observed staff speak openly and loudly about personal care needs. We heard staff telling people loudly, "I'm going to change your pad." With another staff member following it with, "I get all the best jobs." One person was told by staff inappropriately that the inspectors were in the home to check they were behaving. The person was living with dementia so may not have fully understood any humour intended.
- We observed a person be taken to the toilet which was next to a communal area. The door was left open several times. The person was in full view of people sitting in the communal area. We had to ask staff to close the door to preserve the person's privacy and dignity.
- The approach in the home was task led. Staff were busy and morale was low which impacted on their ability to see the small things that were important. Some staff were heard being friendly and attentive, however, this was not consistent throughout the home.
- A relative told us, "I find [person] in bed with food all over the bedding sometimes and her teeth are not put in or her hair is a mess."
- We also found that a person had an object that gave them comfort, and this was noted in their care plan as being important to them. However, this had been lost and while there were posters displayed in the unit to locate the object, it had not been found.

People's dignity was not promoted. This was a breach of regulation 10 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

- People and their relatives said that most staff were kind. They said there were some that were not as friendly as others. One relative said, "They do their best, they are caring and kind." One relative told us, "Everyone is so friendly, regardless of their role in the home."

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

- People and their relatives gave mixed views about if they were involved in decisions about their care. They told us they were kept informed about changes but not sure they were part of the review process. One relative said, "Staff always let me know anything affecting [person]. For example, they call me if [person] has

had a fall or feels unwell." Another relative said, "Staff don't listen to relatives. We know the person and have so much information to share."

● People's care plans included a record of people's preferences and choices in most cases. However, it was not clear from reviewing plans how much involvement people and their relatives had with the monthly reviews. A member of the senior management team told us, "On review and discussion with the team at Providence Court, they are involving residents in the care planning process however evidencing involvement in the person's care plan is something that the home are currently working on."

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 good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

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 told us there were not many activities they could participate in as there was not many activities available. A relative told us, "[Person] is not happy because they are bored, there is no interaction with other residents and staff are too busy." Those in communal areas who were able to express their views told us they were bored. Others who were cared for in bed, those who struggled to communicate, had very little interaction from staff. One person whose care plan stated they like to watch TV, was lying in bed with a TV on but could not see the TV over the bedrails. There was someone in post to provide activities, but time given to this was limited. We saw a game of skittles was started during the visit. A member of the regional support team was the only person who tried to drum up people's involvement with it.

● We asked staff about things for people to do. One staff member said, "Our [streaming device] is broken, but when it's here we used it to do the hokey cokey or something." When asked the staff member was unable to tell us what else activity wise was on offer as could not think of anything.

● Staff told us they did not have time to spend doing activities. On one unit we noted staff were standing around in between care tasks and these were missed opportunities to engage with people.

● We reviewed a record of activities provided and found the entries included hair brushing, listening to music, TV and if they had a visitor. However, for those people receiving care in bed or isolating there was an increased risk of loneliness and social isolation. There were chats recorded and some entries for activities such as singing, bowling and relaxation.

● A recent residents meeting held by an activity person, listed all the events planned for November 2022. This included pictures of events. We saw that the December activity schedule had things planned for every day.

● People were supported to maintain contact with family and friends. Relatives told us that they were supported to keep in touch with their family members.

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

● People gave mixed views about the care they received. Some people were not able to verbally communicate their views, so we used our observations to assess the standard of care. Relatives also gave mixed views about the care provided. However, one relative said, "The care [person] receives at Providence Court gives me peace of mind. I would most certainly recommend the care home."

● People were dressed appropriately for the cold. Care notes viewed indicated that care was given when needed. However, even though one person was recorded as having received continence care, the person was still very wet. In addition, due to their assessed needs their care plan stated, 'I have a high level of emotional or mental health issues, needing fairly constant staff intervention.' However, the person was left

alone between all care tasks.
● People's care plans, in many cases, included information to guide staff so care could be delivered in a person-centred way. However, we found that staff did not all have access to this information and nor did they have good knowledge of people or their needs. Also, some plans were not up to date. For example, one person's plan said they were to be cared for in bed due to mobility and pain. However, they were up and about during the inspection.
● We also found that some plans did not include all required information, such as a falls care plan not including when a person was on blood thinning medicine and the impact this may have.
● Also, plans were not always putting the person first, but instead considering staff needs. For example, one plan stated that the person may make inappropriate comments to a gender of staff. Rather than ensuring staff had the skills to manage this or providing a different gender of staff, the decision was made for two of staff of the same gender to provide personal care. The person did not need two staff for their needs so this was an unnecessary action which impacted on the person's care.

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.
● People's care plans referred to communication needs and if people were able to communicate verbally or not. However, they did not provide any guidance to aid communication should a person not be able to communicate easily.
● One person whose first language was not English, at times struggled to communicate. The manager told us that staff had flash cards to aid communication. However, staff were not aware of these and despite the person being distressed did not use any picture cards or translation aids to help the person express themselves.

Improving care quality in response to complaints or concerns
● People and their relatives told us they had complaints. However, some relatives told us that they did not always get a response. One relative said, "I was promised a call back, but it didn't happen." However, another relative said, "I have made a couple of complaints: About the issues mentioned already. The response was very good and immediate."
● The provider had a system in place to record and monitor complaints. However, it was not clear how the provider had used these to help improve the standards of care in the home or respond to complaints. We did see feedback in staff meetings about some issues raised.

End of life care and support
● Some people's care plans included some information about the end of their lives. Two of the six plans we viewed had a note the person had declined to discuss their wishes and the other said, not discussed.
● The staff team supported people at the end of their life. Senor care staff engaged with visiting healthcare professionals to ensure their needs were met. While staff at the home were supported by the team from the local hospice, only eight staff members had received training for end of life care.
● Feedback seen reflected that relatives were grateful of the time and care from staff when supporting people at the end of their lives. We reviewed positive feedback sent to the home about the care family members received.

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

- The management team were carrying out audits and checks to monitor the service. However, even though they had been aware of some issues within the home, action they had taken had not been effective to address the shortfalls. We had concerns about safety and management of risks and changes in health needs, dignity and staffing which had not been identified by the management team or the audits undertaken.
- A provider audit had identified issues in September 2022, but this remained a concern two months later. For example, the shortage of handheld devices so staff could access information about people and record care given. There had been no steps taken to ensure staff had readily accessible information during this period. For example, handover forms had not included people's risks and basic needs, even though some staff did not have awareness of full needs and agency staff were used at the home.
- The lack of consistency of walk rounds and checks had also been identified, but this remained less frequent than the planned daily checks. We were told by the regional management team they had noticed a change in the standards in the home as far back as July 2022 but action to address this had not made the required improvements.
- Feedback from people and relatives about the management was mixed. One relative said, "I raised a complaint or more of a query about [issue] but the temporary manager who promised to call me didn't. I don't know who the manager is now." Another relative said, "They (management) will sort out any issues if you tell them. They just don't seem to notice any issues themselves." Another relative said, "We get emails from the home to tell us of management and staff changes and staff on the unit keep us up to date with any changes too."
- Staff told us the management team had rarely checked they were working in accordance with guidance and standards and they did not feel supported. One staff member said, "Morale is very low due to four managers in a year. All staff loved [previous manager] but said [manager who recently left] unpicked all the good they had achieved. Staff do not feel supported or valued."
- The management did inform relatives when there had been an issue, in most cases, involving their family member. However, some relatives told us that appropriate action had not been taken, for example, following a fall, or they did not get a response when they raised an issue.
- The provider did send statutory notifications, however, at times these were missed. For example, for a

recent medicines error that needed to be reported as a safeguarding concern. In addition, the content in the notifications was poor, we repeatedly needed to ask for more information to be assured the required actions had been taken.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people, Engaging and involving people using the service, the public and staff, fully considering their equality characteristics, Continuous learning and improving care

● There was a lack of attention to detail and recognising care issues. For example, management of pain, recognising concerns with people's health issues in some cases and making sure people had their comfort promoted. One person had a health condition that caused red and irritated eyes, but their eye drop course had finished 12 days prior to this inspection. There had been no follow up when there was a lack of improvement to help relieve the person's irritation. Another person had a sofa cushion instead of a pillow on their bed for three days.

● The governance systems had not identified there was a lack of engagement for people. During our visit people told us they were bored, and we saw very little staff interaction with people. There were limited activities planned or in progress and the activity that did go ahead reached only a few people. However, this was due to a regional manager walking round and encouraging involvement.

● We found that the culture in the home did not always promote dignity or ensure people's needs were always met. People were spoken with in a way that did not show respect, ensure care needs were not missed, and staff felt it was acceptable for someone to use the toilet in view of other people. We found these concerns within a short time of being in the home, observing practice and speaking with people. However, the provider's governance systems and the lack of effective leadership meant this had not been identified by the management team.

● Staff morale was low in the home and some staff had fallen into bad habits regarding their practice and they had not received appropriate leadership and support. One staff member said, "We tell them (management) about what we need and issues, but nothing happens."

The issues found within the homes governance monitoring systems had an impact on people's safety and standard of care received. Therefore, this was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● There were meetings for staff. These covered key points to be aware of such as infection control, fire safety and expectations of the team. There had been a resident meeting in November 2022 led by the activities organiser which gave reminders to people about what to do if they had concerns, people were asked about the menu and activities coming up.

Working in partnership with others

● The registered manager had linked in with a local care provider's association to help provide training opportunities.

● Health professionals who supported the home raised areas of concern which we had also identified in the home. One health professional said, "I want to support the new management team and help them achieve some stability and get their processes updated. They cannot do this whilst they are firefighting and accepting new residents." Another health care professional who supported the home told us, "The deputy manager has always been helpful and appears to know her residents and what is happening in the home. The staff are always welcoming in the home." However, they went on to say that at times when asking care staff about a person they were sometimes told they did not know.

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 HSCA RA Regulations 2014 Staffing People needed to wait for support and staff skills and knowledge were not consistently updated or in place to ensure people's safety.

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 10 HSCA RA Regulations 2014 Dignity and respect People were not treated with dignity and respect.

The enforcement action we took:

We issued a warning notice to help ensure improvements were made in a swift timescale.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's safety was not promoted.

The enforcement action we took:

We issued a warning notice to help ensure improvements were made in a swift timescale.

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 People were not protected from the risk of abuse as robust procedures were not followed.

The enforcement action we took:

We issued a warning notice to help ensure improvements were made in a swift timescale.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems to not identify or address shortfalls in the home that put people's safety and welfare at risk.

The enforcement action we took:

We issued a warning notice to help ensure improvements were made in a swift timescale.