Avon Care Homes Limited

The Wells Nursing Home

Inspection report

Henton
Wells
Somerset
BA5 1PD

Tel: 01749673865

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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
The Wells Nursing Home is a residential care home providing personal and nursing care for people aged 65 and over. At the time of the inspection there were up to 26 people living at the home and two people were completing short stays. The service can support up to 40 people. People had mixed ability on how much they could tell us. We used observations to capture experiences of those with less verbal communication.

Each person had their own bedroom in the home and there were shared facilities. There was a garden people could access plus a lounge with a conservatory area and a dining room.

People's experience of using this service and what we found
People and their relatives reported mixed feedback about the service including how safe they were. We found people were not safe at the home. Risks had not always been considered or managed effectively. Concerns continued to be found for people at risk of pressure ulcers and choking. There were not enough staff to keep people safe and meet their needs. Recruitment of new staff was not in line with current legislation. Staff had not always received enough training to keep people safe.

The management of the home had been inconsistent since the last inspection. Quality assurance systems had not identified all shortfalls found during this inspection. Lessons were not being learnt from concerns being raised at the home. We made a recommendation about this. Systems to protect people from potential abuse were not always working. Potential safeguarding was found that had not been alerted to the local authority or the Care Quality Commission.

Communication was sometimes at an issue at the home due to many staff having English as a second language. There was a high turnover of staff and high use of agency staff. There was a culture that was not always condusive to delivering good care at the home. Care plans were mixed, lacked guidance for staff and contained inconsistencies. One person did not have a complete care plan.

People were not always supported to have maximum choice and control of their lives and staff did not always demonstrate they had considered the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice.

People's privacy and dignity was considererd some of the time. Some people and relatives felt there was good care at the home. Most people were positive about the food offered at the home.

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 14 February 2019) and there were multiple breaches of regulation. The provider failed to send us an action plan in line with current regulations. At this inspection enough improvement had not been made and the provider was still in breach

of regulations.

Why we inspected
This was a planned inspection based on the previous rating.

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

Enforcement
We have identified breaches in relation to safe care and treatment, managing risks, protecting people from potential abuse, recruiting new staff in line with legislation, notifying the Care Quality Commission in line with statutory requirements, ensuring people receive personalised care from suitably qualified staff and ensuring systems were in place to monitor and manage the service.

We are mindful of the impact of 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 regularly monitor the service including requesting an action plan to be submitted to keep people safe.

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

The 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 caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate

The Wells Nursing Home

Detailed findings

Background to this inspection

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

Inspection team
One inspector and one specialist advisor (SpA), who was a nurse and had a background in similar types of services, were at the home for three days. A member of the medicine team completed the first day of the inspection.

Service and service type
The Wells Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission at the time of the inspection. A registered manager means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from other health and social care professionals who had regular contact with the home. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with 18 people in various detail, five relatives and one health professional. We spoke with 17 staff including the manager, nurses, care staff, an activity coordinator and auxiliary staff. We reviewed a range of records. This included 20 people's care records in a variety of detail and 19 medication records. We looked at five staff files in relation to recruitment and staff supervision records. We also looked at a variety of records relating to the management of the home including policies and procedures and health and safety records. 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 spoke with the fire service, the local authority and the regional manager on the telephone. We continued to seek clarification from the provider to validate evidence found. We looked at training data, quality assurance records and other information the provider sent us.

Inadequate

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last inspection the provider had failed to ensure people were receiving safe care and treatment including managing risks. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● People continued to be at high risk of choking. One person had recently been assessed by a speech and language therapist (SALT) in relation to potential choking risks. Instructions had been given for staff to give them thickened drinks and softened food. Staff should also support them to eat and drink. The person was given biscuits and drinks with no support from staff. At lunch time staff did not thicken this person's drink or use a closed beaker with a spout in line with the SALT guidelines. The inspection team had to step in multiple times to keep the person safe at the beginning of lunch. One member of staff had not been told about the changes to the person's eating and drinking. For another person staff had to visit the GP to get a copy of their eating and drinking plan from the SALT as there was not a copy in the home for staff reference.
● People were still placed at risk of potential harm around pressure care. Special air mattresses in place for One person was incorrectly set meaning incorrect pressure could be placed on fragile skin. Their air mattress was set at 80kg and they only weighed 58kg. Two other mattresses had the wrong settings written for staff to refer to when they completed the checks. We also found mattress alarms had been muted meaning staff were at risk of not being alerted if there was a fault. We were informed of one occasion where a mattress had fully deflated recently for a person with a significant pressure ulcer which was referred to in a provider investigation. Another person had a pressure ulcer on their ankle which was meant to be kept raised; it was not seen raised once during the inspection.
● Staff continued to inconsistently record daily monitoring of people's specific fluid intake and repositioning. One person was meant to have their fluid intake monitored due to risks. On the first day of inspection staff left this person's drink in their bedroom and did not record their fluid intake. On the third day a small amount was recorded. Another person was meant to have 2300mls per day; throughout the day nothing had been recorded. Care plans lacked details of repositioning frequency and we found daily records which had minimal entries of repositioning recorded.
● People were placed at risk of harm if they required catheters. Care staff had little understanding of how to empty the bags safely and told us they had received no training. One person had a high risk of infections. Another person had been given a large catheter with no explanation in line with current guidance. Nurses

were not clear about current best practice in relation to catheter use.
● Staff sometimes had limited guidance on how to support people with behaviours which could challenge themselves or others. One person whose behaviours had changed recently had nothing in their care plan to guide staff. A safeguarding was related into the way this person's behaviour was allegedly managed.
● People were at risk of not being transferred appropriately by members of staff. We observed one person being supported to move back in a chair using an inappropriate technique by a member of staff. Another staff member tried to intervene when it happened. On the first day of inspection some practical training in relation to this was cancelled; this had included the staff who had been observed moving a person inappropriately. Some staff disclosed to us they had seen inappropriate techniques used at different times at the home. This included people who had fallen being lifted from the floor by staff without using a hoist. No accident or incident form was found in relation to this.
● People continued to be at risk of pain especially at the end of their lives. Prior to the inspection we had been alerted of two occasions where people had not received adequate pain killers in a timely manner. During the inspection, one person receiving end of life care had records demonstrating they waited 36 hours from a staff member recognising pain until they received pain relief. On the days we were there this person appeared comfortable.
● Environmental risks had not always been considered. No weekly or monthly visual checks had occurred since January 2020 according to records. This included for the call bell system, window restrictors and wheelchairs. Concerns were found with damage of some call bells and lack of available call bells in communal areas of the home. One routine check for the hoists had flagged up an advisory concern for a bath hoist. no action had been taken in relation to this.
● Risks in the event of a fire had not always been considered. There was no grab bag near the exit and fire doors were propped open or had rubbish placed in front of them. A grab bag contains important contact information needed in the event and equipment such as blankets, first aid kits and torches. We found any routine checks in relation to fire safety stopped in January 2020 when no replacement book had been provided. Following the inspection, we referred our concerns about fire safety to the fire service.

Systems were not in place to ensure people received safe care and treatment including the management of risks. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Risks for staff living in the home had now been assessed and a policy was in place. However, the policy had not been signed by two of the staff currently living in the home to state they had seen it and understood it.
● The manager had plans to introduce new records to be kept in each bedroom. Their aim was to record things like repositioning and fluid intake more accurately.

Staffing and recruitment
At our last inspection the provider had failed to ensure people were receiving safe care and treatment including managing risks. This was a breach of regulation 19 (Fit and Proper Persons Employed) 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 19.

● Recruitment was still not in line with current legislation. One staff member had two references with no evidence they were completed by a previous employer. They were on the provider's own headed paper. The regional manager told us they did have emails to demonstrate they were completed correctly. We have not

seen them.
● Discrepancies were found in recruitment records between the employment dates on application forms and the corresponding references. No exploration about this had been completed.
● Incomplete or unsigned forms were present in staff recruitment records including for supervisions and application forms.

Current legislation had not been followed to ensure people were supported by staff who had been through safe recruitment. This was a continued breach of regulation 19 (Fit and Proper Persons Employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were not always supported by enough staff to keep them safe and meet their needs. There were mixed opinions about whether there were enough staff. Comments from people included, "They [staff] usually answer the call bell quickly. Today I had to wait half an hour", "They are short of staff" and, "Staff are doing their best, but they are overworked…Night times are the worst."
● People were left in their bed all day even if there was no care or health need. Staff told us, and records, confirmed people did not have a bath. One relative confirmed their family member had been refused baths because staff did not have the time.
● During the inspection, we observed three people in the lounge for half an hour with minimal contact from care staff. One person nearly fell multiple times from their chair trying to get up; they were stopped by a member of staff who did not have adequate moving and handling training. This person had a history of falls.
● The provider did not have a system to identify the dependency of people in the home. The manager told us the staff levels were based upon occupancy rather than need at provider level. The regional manager told us they did have a dependency tool to calculate staff levels, although it was not used at the home.

There were not enough staff to people's health and care needs. This is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● People had mixed views about how safe they were living at the home. Some told us they felt safe at the home when asked. Whilst other comments included, "One or two are a bit funny…they tell you not to do that", "Some know what they are doing, some do not", "I like some better than others. Some are more friendly than others", "Hit and miss. The nice don't stay long" and, "Agency do not care about it [meaning a sore health condition] and are rough".
● Allegations were made during the inspection about incidents which demonstrated people were not being protected from potential abuse or improper treatment. We were told one person had been, "Shut out like a caged animal" in the conservatory because they were upsetting other people. The records for the person on the alleged date indicate a referral was made to the GP for a medicine review. Their daily records contained information indicating how upset the person was on the alleged date.
● Another person described an event where they had been held against wooden bed rails during a nursing procedure despite them alerting staff it was hurting. We saw they still had bruising to their face and hairline a week after the event. They told us they had felt pain and the staff would not let go. This incident had been investigated by the provider and had been referred to the local authority safeguarding team and the person's GP. However, different versions of the event were within the records and what we were told during the inspection.
● Systems were not always effective in protecting people from potential abuse. There had been an allegation of a person having their wrists held by an agency staff member. There was record of this agency staff member returning to the site at a later date despite an investigation starting. No notification to CQC or the local authority safeguarding team had been made.

● Another potential staff member was living in the home without the correct criminal record checks in place. They had been prevented from working any shifts until the correct checks were completed. However, no consideration had been made about having them living in the home. We raised our concerns and the risk was removed for people by the potential staff member leaving the home.
● Occasionally during the inspection inappropriate language was used to describe the people living at the home. One staff member referred to a person as a, "Difficult person."
● During and following the inspection, we raised safeguarding concerns to the local authority.

There were no systems in place which were effectively protecting people from abuse or improper treatment. This was a breach of regulation 13 (Safeguarding Service Users from Abuse and Improper Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● Medicines were not always managed in line with current best practice. There were protocols for some medicines prescribed to be taken 'when required', to guide staff as to when it would be appropriate to give a dose. However, we found that these were not fully completed for all medicines prescribed this way. We also saw that they were not always reviewed in the timescales written on them.
● Medicine records appeared completed and doses signed as administered in accordance with the prescription. However, issues were identified that people could be prescribed a topical cream which was signed by a member of staff who had not applied them. This led to a risk people may not receive their prescribed topical creams.
● Information about changes to medicines with the medication administration charts was not always clearly recorded. We saw changes had been made to a person's medicine regime following a doctor's visit that may have affected the person's pain control and it was not reflected in the MAR.
● Systems were in place to report any medicines errors or incidents. Regular medicines audits were completed. When issues were identified actions for improvement had been recorded. However, some of the areas of the audit did not reflect current best practice.
● Suitable arrangements for storing and disposal of medicines, including those needing cold storage and extra security had suitable arrangements.
● Medicines were administered using a safe method. Where staff were making the decision about administering pain relief an assessment of pain level was carried out before administration. A follow up assessment was seen to be carried out after the administration.

Preventing and controlling infection
● People were not always being protected from the potential spread of infection. Staff were seen moving between areas of the home wearing the same pair of disposable gloves or aprons. By not changing these between areas and washing hands they were removing the effectiveness of them.
● Most of the time the home smelt pleasant and was clean. There were cleaners who made sure the home was kept fresh.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now remained the same. 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

At our last inspection the provider had failed to ensure staff were trained and skilled to deliver appropriate and safe care. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

- People continued to be supported by staff who had not received adequate training to meet their needs. Since the last inspection work had been undertaken to improve training for staff. However, the systems in place lacked some key training for nursing staff. Neither were there systems to ensure staff were competent in the different tasks being carried out at the home.
- Three staff had not received manual moving and handling training. Additionally, we were told the training recorded did not include practical sessions on how to safely transfer a person. On the first day of inspection the practical training was due to happen for seven staff; it was postponed by the provider. One person was witnessed inappropriately transferred by a staff member during the inspection; the staff member was due to attend the practical training.
- Training records demonstrated staff were either out of date or had not received annual training in several areas in line with the provider's requirements. For example, out of 15 care and nursing staff, five required annual safeguarding training and seven staff still required their annual fire safety training.
- New staff and agency staff who had not been to the home for a long time received a basic induction. One agency staff had not worked at the home for four weeks and staff had updated them about the changes to people living at the home.
- Supervisions were not happening regularly for staff. The overview showed there had been none recorded since June 2019. Records of supervisions went as far as September 2019. Staff had mixed views about how much supervision they had received.
- The regional manager informed us most of the training for staff was delivered in their own language if English was not a first language. However, it was not clear whether there were systems in place to ensure staff whose English was not their first language were competent.

There was not enough support, training or competency checks completed for staff so they could meet people's needs. This is a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

● The manager had plans to rectify the supervisions and talked us through how they would move forward with them. They told us some historic training records had been lost prior to them starting.

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 a range of health and social care professionals. However, staff did not always follow their guidance in a timely way. Prior to the inspection we had been informed when people at the end of their life had not received adequate pain relief in a timely manner. We investigated these concerns and found there were issues of instructions not being followed and methods of continuous pain relief was not delivered in a timely way.

● One person had a pressure ulcer. A health professional had given clear guidance about what actions needed to be taken. Their care plan had not been changed to reflect this. During the inspection, we did not see the guidance being followed. This placed the person at risk of their ulcer getter worse.

● Other people had not had timely referrals to other health professionals. For example, the person who was at the end of their life during the inspection. Other people did not have easily accessible eating and drinking plans from the speech and language therapist.

There was not enough support, training or competency checks completed for staff so they could meet people's needs. This is a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Specialists were consulted such as tissue viability nurses and speech and language therapists when people had a specific needs.

● During the inspection we saw a range of health professionals visit the home to support people. One health professional told us they had overheard other staff receiving instructions in line with their guidance. They said, "If there is a problem they phone me and I come."

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

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

At the last inspection we made a recommendation that the provider seek advice and guidance from a reputable source in relation to the MCA and DoLS. The provider had made some improvements though practices were not consistently being applied.

● DoLS had now been applied for when it was necessary. However, one person had conditions on an authorised DoLS. Some of these had been met although one relating to "asking to go home" was not known by all staff. There was inconsistent recording of this as well. For example, on the second day of inspection they were witnessed asking or trying to go home multiple times. Their daily records contain no information about this.
● All restrictive practices did not have MCA and best interests in place for them. One person required a special mat to alert staff if they tried to get up to prevent falls. This had been mentioned in their DoLS. However, there was no MCA or best interest decision completed to state it was the least restrictive option and those individuals important to the person agreed with the practice.
● Other people had MCAs and best interest decisions completed for visiting health professionals. However, those important to them always been involved in the decisions. For example, one person who had two relatives holding health and welfare decisions issued by the Court of Protection had no record of consultation .
● People who were able to consent had care plans with a note to state they had been consulted.

Supporting people to eat and drink enough to maintain a balanced diet
● People were mainly positive about the food and drink they could have at the home. Comments included, "Get a good cup of tea", "The food is good" and, "Very good. Brilliant." However, one person did not feel they got much choice. The visual choice board in the corridor lacked options for the meal of the day.
● Staff were not always able to access the specialist eating and drinking plans for people. They were not always followed by staff.
● The kitchen staff had recently reviewed how they kept up to date with people's eating and drinking needs. However, one member of kitchen staff was responsible for distributing people's mid-morning drinks. They left those to be thickened in bedrooms out of reach. On occasions we found these drinks had been left untouched and tepid still in people's bedrooms 10-15 minutes later.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People did not always have their care needs assessed and there were inconsistencies in care plans. Some people had their plans updated when their needs changed. Again, this was not consistently applied.
● Oral health care had been considered and care plans were in place. However, staff had received no training in how to support people's oral health.
● Latest standards and guidance was not always applied consistently. For example, some care plans had moving, and handling plans in line with the Health and Safety Executive guidance and others did not.

Adapting service, design, decoration to meet people's needs
● People were able to decorate their bedrooms in line with their needs and wishes. Some had photographs whilst others had ornaments from their previous home.
● However, parts of the home appeared to need repair or updating. One person's bedroom had a broken curtain rail, and another had a call bell point which was broken. Trolleys to keep food warm were currently being replaced because they were rusted.
● Concerns were raised from a variety of sources that the main lounge had no call bell point. The regional manager told us there was. We saw no evidence of call bells being used in it.
● Parts of the home were laid out to look smart and ready for use such as the dining room. However, minimal consideration had been made for people with memory difficulties caused by things like dementia.

Requires Improvement

Is the service caring?

Our findings

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

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

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

- People had some mixed opinions about how well treated they felt. Comments from people included, "Staff are pleasant and interesting", "Staff are very friendly and caring" and, "Staff do their best". However, there were other people who had different experiences with staff at the home. Some people shared experiences with us which indicated staff were not treating them kindly.
- Throughout the inspection we saw some staff speaking in a kind and caring way with people. This included having a joke with a person or involving them in what they were doing. However, there were other staff who were task focussed and did not acknowledge people when passing. On one occasion we observed a person lying in bed coughing and two staff walked past without checking the person was alright.
- Relatives had mixed opinions. Comments included, "Staff are nice", "Staff are very nice" and, "The care staff are ambivalent; they do not care." One health professional explained they saw happy people whenever they attended the home.
- Compliments shared with us reflected positive experiences people had at the home. Examples read, "I have found all the staff and manager to be excellent in the care and respect for mum" and, "I have always found Wells Nursing Home to be a very friendly and helpful place."

Respecting and promoting people's privacy, dignity and independence

- People's privacy and dignity was not always considered when some practices occurred at the home. For example, when we arrived at the home the shift changeover and handover appeared to be carried out round the downstairs nurse's station in the corridor. This did not consider the confidential information being spoken about.
- No systems were in place to ensure people receiving health care in a communal space could have their privacy and dignity respected. We shared this with the manager who said they would review practice when people had appointments and chose to remain in a communal space.
- Staff mainly knocked on bedroom doors before entering them. All intimate care was delivered in private to protect the privacy and dignity of the person.

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

- People had some opportunities to make choices. When they made them staff did respect them. One person chose what drink and cake they were given. Other people chose to join in activities at the home.
- However, some people had little choice about where they spent their days at the home. One person told us they would enjoy getting out of bed; there was no reason why they needed to stay in bed. We saw them in their bed all day.

● Options were provided during meal times of different choices. This included meat and vegetarian options. If people were not happy with the choices, then the kitchen staff would prepare an alternative meal. Minimal systems were in place for those who had minimal verbal communication to select what they wanted for meals.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now remained the same. 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; End of life care and support

- People continued to not always receive personalised end of life care and support in line with current best practice. Some care plans had information about their choices and wishes whilst others had limited information.
- Staff lacked specific skills and knowledge of how to support someone in their final days of life. Some staff completed appropriate tasks such as repositioning and mouth cleaning. However, other staff continued to try to complete invasive checks despite a person being deemed near the end of their life.
- Care plans for people at the end of their life lacked specific, personalised information. For example, there was no guidance around mouth care, spiritual or cultural choices and acknowledgement or details of specific wishes to be fulfilled.
- People's care plans did not always contain adequate information to provide clear guidance for staff around areas of risk meaning potential inconsistent support and not personalised. Although some staff had worked at the home for a long time, there was a high turnover of staff and use of agency staff who were less familiar with the people. Examples of this were seen when making sure people were kept safe.
- Some care plans contained inconsistencies or had missing details. One person had moved into the home recently and they had an incomplete care plan. By the second day of inspection some risks had been considered. Though detailed information and guidance was not in place. Other people had a mix of information which provided contradictions or used generic statements which were not personalised.
- Key information was sometimes missing to ensure consistent and personalised support for people. One person had a change in anxiety levels and their care plan did not reflect this. Some people required equipment for transfers and their care plan had limited information and guidance about the specific equipment required for this.

Care plans did not always contain personalised details and on occasions lacked key information to support a student. This was a breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People had mixed opinions about the activities on offer in the home. Some people attended a pottery session run by an external visitor. Those participating were clearly enjoying themselves. Other people had sessions with the activity coordinator and clearly appreciated the interaction.
- However, when the activity coordinator was not working in the home there was little activity or interaction

from the care staff who were busy. People were seen sitting in the lounge occupying themselves. At times this led to people becoming frustrated. One person was banging a cup on the table repeatedly; their care plan stated this was a sign of "Agitation."

● Some people chose to spend time in their bedrooms watching television or listening to music. However, there were occasions when the activities did not appear to match a person's interest. One person expressed a dislike for the music being played on the radio. The same music was in most of the bedrooms on that floor.

● Visitors were welcome at the home to visit whenever they liked. We saw relatives coming at various times of day. Some relatives shared how frequently they were at the home.

● People's religious and cultural needs had been considered to some extent. There were opportunities for group worship at the home by visiting churches. However, one person from a different cultural background had little consideration of this in their care plan or at the home.

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.

● Some consideration had started to be taken at provider level to ensure the AIS was implemented at the home. Picture cards had been developed to help people communicate their meal choices. However, these were not consistently being used in the home. On the first day there was one option for the main course and pudding put up for lunch.

● People who had specific communication needs sometimes only had generic guidance and not personalised to them. For example, one person had hearing difficulties. There was little guidance other than generic statements in their communication plan to instruct staff the best way to help them understand.

Improving care quality in response to complaints or concerns

● People knew how to complain and who to raise concerns to. One person told us they would speak with the manager. However, there were occasions when people expressed less confidence in speaking up.

● Systems were in place to manage complaints. Responses had been provided including meeting with one relative. However, there appeared to be a lack of learning from two recent complaints. These were on a similar topic and further concerns were found on the same topic during the inspection.

We recommend that the provider reviews current guidance on learning from complaints and takes action to apply this.

Inadequate

Is the service well-led?

Our findings

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

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

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

At our last inspection the provider had failed in line with their legal obligations to notify the Care Quality Commission (CQC) of significant events. This was a breach of regulation 18 (Notifications of Other Events) of the Care Quality Commission (Registration) Regulations 2009.

There had been some improvement, although not enough consistently and the provider was still in breach of regulation 18.

● Since the last inspection there had been some notifications to CQC. This included notifying CQC that DoLS had been authorised and there had been some incidents.
● However, some incidents were found which had a safeguarding nature and had not been notified to CQC. For example, one person was inappropriately supported by an agency staff and had a significant issue with their pressure relieving air mattress deflating completely. On another occasion a safeguarding had been raised by an external party and the provider had not informed CQC. Another alleged safeguarding incident was notified to CQC during the inspection. The manager had attempted to report it when it first happened a week before the inspection. The notification had failed, and no further attempts had been made by the provider or manager.

CQC had not been notified in line with the provider's statutory requirements for all significant incidents. This was a continued breach of regulation 18 (Notifications of Other Events) of the Care Quality Commission (Registration) Regulations 2009.

● The provider and manager failed to have governance and oversight that led to effective monitoring of care and improvements. This placed people at risk of potential harm and risk of their needs not being met consistently and safely. This also led to multiple breaches in the regulations.
● There was a high turnover in staff, and we saw occasions when a lack of monitoring of people to keep them safe occurred. The management had no system in place to identify the current dependency of people the home to make sure enough staff were on duty to meet people's needs and keep them safe.
● There had been an inconsistent level of improvement or leadership since the last inspection. This led to repeated concerns at the service. There had been no registered manager since January 2019. Although, the

provider had attempted to replace the registered manager.
● The provider had failed to submit an action plan following the last inspection to demonstrate how they were going to improve the service and in what timescales. The action plan shown to us during the inspection was incomplete with key details used by CQC to identify a home. Neither did it contain information about when it was sent to CQC. The regional manager did not provide information such as a reference number or email to demonstrate it had been sent.
● Care and nursing staff were not receiving regular supervisions meaning there had been limited opportunity to discuss training requirements and practice. There was incomplete information to demonstrate staff competency was regularly checked for practices such as safe transfers of people.
● Inconsistencies were found with safeguarding, the application of the Mental Capacity Act, care records, end of life care and staff training.
● Communication and understanding was a concern identified during the inspection. One relative said, "It has really gone downhill here" and when asked why they said, "Communication. Carers mainly do not speak English. They do not understand [my relative] and [they] do not understand [them]." Members of the inspection team had to explain things multiple times to some staff, so they understood what they were saying. The provider had tried to take some action to support staff from other countries. However, their actions did not appear to be enough to ensure people received safe care which met their individual needs.
● The provider demonstrated a lack of learning from significant events which had led to formal complaints. Examples of this were seen around end of life care and pain management and repeated breaches.
● The provider had not ensured current best practices had been followed at the home in relation to care and treatment provided to people. Examples, of the shortfalls were seen throughout the inspection including medicine management, catheter care, end of life care and choking risks.
● Mixed views were heard about the culture which had developed in the home. Some staff, people and relatives were positive about it. However, some concerns were raised that suggested people did not always receive good or safe care as a result of it. This included the way some of the care staff were spoken to by some of the nursing staff. Also, we were informed how un-welcome new staff were made to feel.
● The management were not always following the providers own policies and procedures. For example, around recruitment and safeguarding.

The lack of effective oversight, governance and quality monitoring arrangements was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection the regional manager sent us an action plan to demonstrate how they were going to manage immediate risks to people. They explained they struggled to access some information we required due to a technical issue.

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 manager had understanding and acted upon their duty of candour. During the inspection we saw examples of where they had informed relatives about accidents and incidents. However, one concern raised during the inspection had not been informed to the relatives before we spoke with them.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The manager had demonstrated changes they had made to include people, relatives and staff more fully in the running of the home. People knew who the manager was and felt they listened. One person told us of a recent change made by the manager in response to an issue they had raised. This had made them happy.
● The provider had recently updated the organisational chart to make it clearer to staff the current

management structure in the home. Staff appeared to know who they reported to.
● Some consideration had been made by the provider to reflect staff's individual needs. This included reviewing which staff worked together when a specific need was identified.

Working in partnership with others
● Positive links had been built with some specialist health and social care professionals. This included gaining advice for specialist needs people had. However, further links needed to be developed where there were weaknesses at the home such as end of life care.
● Links had tried to be developed with the local community by the current manager for example with the local schools. These had not been reciprocated.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not notified the Care Quality Commission in line with statutory guidelines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider was not ensuring care was person centred and reflecting peoples individual needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not ensuring people were receiving safe care and treatment at the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider was not making sure people were safe from improper treatment or abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not in place to monitor and

improve the service to keep people safe and meet their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not have systems to make sure staff were recruited in line with current legislation to keep people safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider was not ensuring staff had received adequate training or support.