S3 Care Ltd

The Magnolia Care Home

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
The Magnolia Care Home is a residential care home providing personal and nursing care to 28 at the time of the inspection. The service can support up to 38 people in one adapted building. Many of the people using the service were living with dementia. Accommodation is over two floors and there are spacious dining and communal areas on the ground floor.

The provider is in the process of de-registering the nursing element of the service. When this is completed, they will no longer provide nursing care.

People's experience of using this service and what we found
The systems in place to assess, monitor and manage risks to people's health, safety and welfare were ineffective. Timely action had not been taken to implement recommendations from the last fire risk assessment. People were at risk of harm because risk assessments were not always in place for identified areas of risk. Risk assessments were out of date and not regularly reviewed.

Up to date grab sheets were not available to give health professionals key information if people were admitted to hospital. Effective systems were not in place to ensure incidents and accidents were followed up consistently or that lessons were learned to reduce the risk of recurrence. Medicines processes in the nursing unit were not safe in all areas.

The provider failed to have effective systems in place to assess, monitor and improve the quality of the service. Quality assurance processes had not identified widespread issues with care records, risk assessments and medicines which placed people at heightened risk of harm

We have made a recommendation for the provider to review calculations of staffing levels. We could not be assured sufficient staffing were available to offer consistent person centred care.

Not all care files included assessments of people's needs prior to moving into the service. Staff support and development through specialist training and regular supervision required improvements.

Mental capacity assessments and best interest decisions were not in place to ensure decisions were appropriately made when people did not have the capacity to make their own decisions. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Monitoring of people's daily care needs was not consistent which placed people at higher risk of receiving unsafe care. DNACPR (Do Not Attempt Cardio Pulmonary Resuscitation) documentation required urgent review to ensure accuracy.

Systems were not in place for people and relatives and/or representatives to be involved in the care planning and review processes.

We observed warm interactions between staff and people living in the service and staff were kind and caring. Staff who had worked in the service for a while knew people and their preferences well.

Infection prevention and control measures, including a new audit process, were good. Staff followed government guidance in this area to keep people safe during the pandemic period. The décor and furniture in communal areas was fresh and clean, and bedrooms were suitable for people to live in.

Staff were checked for suitability for their roles prior to starting work. This included a police check with the Disclosure and Barring Service.

The provider had completed a comprehensive audit the week before the inspection visit which had identified the issues we found. They were open and transparent throughout the inspection. The provider was aware of the breadth and scale of improvements required in order to ensure people's care was safe and met all of their physical and emotional welfare needs. They were committed to implementing and embedding improvements and had placed an operations director in the service full time to support their action plan.

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

The last rating for this service was inspected but not rated (published 4 September 2020). This is the first inspection of this service under the new provider which can give a rating.

Why we inspected
We received concerns that suggested people received poor care. As a result we undertook a comprehensive inspection in order to investigate these concerns and be able to give the service a rating.

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 coronavirus and other infection outbreaks effectively.

The overall rating for the service has changed from inspected but not rated to inadequate. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvements. Please see the information in all key questions of the report.

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

We have identified breaches in relation to people receiving safe care and treatment, management oversight of the service and personalised care.

Follow up

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.	**Inadequate**
Is the service effective? The service was not always effective.	**Requires Improvement**
Is the service caring? The service was not always caring.	**Requires Improvement**
Is the service responsive? The service was not always responsive.	**Requires Improvement**
Is the service well-led? The service was not well-led.	**Inadequate**

The Magnolia Care 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.

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 and an assistant inspector on the first day. One of the inspectors spent time offsite making telephone calls to staff. On the second day one inspector returned and was accompanied by an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
The Magnolia Care and 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 had a manager who had started in December 2020. They were not available at the time of inspection. They had not yet registered with the Care Quality Commission. This means the provider was legally responsible for how the service is run and for the quality and safety of the care provided.

The provider had placed an operations director in the service full time to provide managerial oversight and support whilst the manager was absent and to implement and drive improvements.

Notice of inspection
The first day of the inspection was unannounced. We called the service ten minutes before entering the

building so we could discuss any risk factors related to COVD-19. We arranged to return the following day to complete the inspection.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We used all of this information to plan our inspection.

During the inspection
We spoke with 10 people who used the service and three relatives about their experience of the care provided. We spoke with 14 members of staff including two directors, two operations directors, deputy manager, floor manager, senior care workers, two nurses, care staff and the cook. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with a professional who worked with the service.

We reviewed a range of records. This included four people's care records and specific areas of a further four people's care records. We looked at multiple medication records and two staff files in relation to recruitment and staff supervision. We reviewed accident and incident reports, team and resident meeting minutes and a variety of records relating to the management of the service. This included quality assurance audits and the recent comprehensive audit undertaken by the provider.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and policies and procedures. We also received information on follow up actions taken by the provider.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as inspected but not rated. At this inspection this key question is now rated as inadequate.

This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Systems and processes to safeguard people from the risk of abuse; Using medicines safely; Learning lessons when things go wrong

● People were at risk of physical harm because timely action had not been taking to implement the recommendations from the last fire risk assessment of October 2020. A number of actions including adjusting doors, installing a new fire door in a main corridor and commencing regular checks of emergency lighting should have been completed within one month and had not been done.
● People were at risk of harm as the system to update risk assessments to reflect their current needs was ineffective. We found assessments for known risks such as malnutrition, skin integrity and falls were out of date and incomplete. COVID-19 risk assessments were not in place for everyone. Risks associated with people's individual needs such as epileptic seizures or use of a catheter had not been undertaken. This placed people at risk of receiving unsafe care which did not meet their current needs.
● People who needed support when they became distressed were at risk of receiving unsafe care. Risk assessments, care plans and positive behaviour support plans were not regularly reviewed. One person's documents were dated June 2020 and their needs had increased and behaviours had escalated since then. Staff did not have up to date guidance on how to offer safe support to people when they were distressed.
● Risks posed by people to others living in the service were not assessed. Some people showed distressed behaviours which impacted upon other people. For example, some people could become distressed and try to hit someone or grab their belongings. Staff did not have guidance on how to reduce these risks or safely manage situations if they arose.
● People did not have effective hospital grab sheets on their care files. We found some grab sheets were out of date and did not contain key information, and some files did not have any grab sheet. This meant if a person was admitted to hospital, health care staff would not have access to up to date information about the person in order to ensure seamless and safe care.
● Systems and processes were not effective in ensuring all incidents were investigated properly. For example, one person had been found in their room with an injury, but no internal investigation had taken place to establish what had happened. We found some incidents had not been referred to the local safeguarding team where there was a risk of potential abuse. This meant all actions to prevent people from harm had not been taken.
● Medicines storage processes and administration in the nursing unit were unsafe. People did not always receive their medicines as prescribed. One person had not received some of their medicines on 15 of the preceding 28 days due to them being asleep or spitting out the tablets. This was not followed up until the first day of the inspection. There were unexplained gaps on medicine administration charts (MAR).

Controlled drugs were not always logged when they were received into the service. This meant people were at higher risk of physical harm from medicines being administered wrongly or not being given.
● In the nursing unit people did not always have front sheets on their medicine records so key information such as a photograph, allergies and whether they received medicines covertly was not available to staff administering medicines. Some people had medicines prescribed to be taken 'as needed'. Protocols giving staff guidance on when these should be administered lacked detail and were not always in place. This heightened the risk of medicine errors which could cause significant physical harm to people.
● There was no system in place to learn lessons after incidents or accidents had occurred. This meant opportunities were missed to reduce the risk of similar events occurring in future.

The provider had not ensured people received safe care and treatment. Therefore, people were at risk of harm. These concerns constitute a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment.

The concerns we found had been identified by the provider in a comprehensive audit the week before our inspection visit. The provider was committed to implementing and embedding improvements to ensure people received safe care. The provider was in the process of de-registering the nursing unit of the service. This would lead to some people moving into the residential unit and some people moving to another service which offered nursing care. We found no concerns about medicines processes in the residential unit. Actions were taken following the inspection to improve some of the medicines processes.

● There was an up to date emergency evacuation list in place which confirmed people's support needs in the event the building needed to be evacuated urgently.
● Staff were aware of types and signs of abuse and had recently completed refresher safeguarding training. Staff were aware of how to report concerns through safeguarding or whistleblowing processes if they needed to.

Staffing and recruitment
● The provider used a dependency tool to calculate staffing levels required in the service. We could not be assured this was effective due to the lack of up to date assessments of people's risks and care needs to base the calculations on. Staff told us they did not think there were enough staff on shift to consistently undertake timely and regular checks on people.
● We saw staff were busy throughout the inspection meeting people's basic needs. We were not assured there enough staff to ensure people received regular person-centred interaction to ensure people were occupied and content. This included people cared for in bed.
● Safe recruitment practices were not always followed consistently. Key documents such as DBS checks and references were in place prior to new staff commencing their roles, but not all files contained a recent photograph or full employment history.

We recommend the provider undertakes a review of staffing levels to ensure there are always sufficient numbers of care, domestic and kitchen staff available all of the time to meet people's physical and emotional welfare needs.

Preventing and controlling infection
● The service had effective infection prevention and control processes and practices in place. Staff were observed to wear PPE appropriately and they had access to sufficient stocks of masks, gloves, aprons and hand sanitiser. PPE stations were located around the service and used PPE was disposed of safely.
● Communal areas were clean and hygienic and regular cleaning took place throughout the service. A visitor

room had been prepared to facilitate indoor visits when it was safe to do so.

● A programme of regular testing of staff and people living in the service was in place. This included rapid lateral flow tests. This meant swift action could be taken if anyone received a positive result.

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 not inspected. This is the first inspection of this key question for this newly registered service. This key question has been rated as requires improvement.

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

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

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

- People's capacity to make decisions, for example to live in the service, manage their own money or have a test for COVID-19, had not always been assessed. Where assessments had taken place, they were not specific and had not been updated or reviewed.
- When decisions had been made in people's best interests, there were no records to support this and no evidence that other people such as relatives and social or health care staff had been involved in the decision-making process.
- Applications had been made to the Local Authority for DoLS appropriately. These had either been approved or were pending, waiting to be processed. We saw evidence of DoLS representatives communicating with the service to make sure people were appropriately supported. We also saw staff had met the conditions attached to some people's DoLS approvals to show people were supported in the least restrictive way.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- Some of the care files we examined did not contain an assessment completed before people moved into

the service. It was not clear how the provider decided whether they could meet a person's needs and whether the person would be compatible with others living in the service.
● Some care plans contained limited information and had not been updated in over a year. Others had been recently refreshed and were person centred. Staff did not have consistent information about people or their current needs in order to provide optimal care and support to everyone living in the service.
● The majority of care plans we looked at required further information about people's individual characteristics under the Equality Act 2010 and other diversity needs such as cultural preferences.
● The provider's recent comprehensive audit had identified widespread shortfalls in the quality of people's care records. They were developing an action plan to start implementing improvements urgently.

Staff support: induction, training, skills and experience
● The staff training matrix showed staff were largely up to date with key refresher training. The service provided support to many people living with dementia, some of whom showed distressed behaviours. Staff had not received any specialist training, beyond online learning, in dementia care or safely supporting behaviours that challenged. One staff member told us, 'We have been asking for it for a while.' This would assist staff and ensure people received optimal care which met their needs.
● Staff told us, and records confirmed, not all staff received regular supervision. Supervision sessions give the opportunity for staff to discuss their role, arising issues, and any other matters. The staff we spoke with were upbeat and enjoyed their roles which was positive for the people they supported.
● Team meetings took place but not on a regular basis. The last meeting was in January 2021 with the newly appointed manager. Minutes were available and a range of issues had been discussed.

Supporting people to eat and drink enough to maintain a balanced diet
● Monitoring of food and fluid intake for people who required it needed improvements. Daily totals were not added up so records showed some people regularly consumed less than one litre of fluids when their target was between one and a half and two litres. Food monitoring charts were inconsistent. We did not find any evidence of dehydration or malnutrition in individuals. A new monitoring chart was introduced immediately with an expectation of daily totals being checked by night staff.
● Choices of meals were available for people. Due to a recent outbreak of COVID-19 meals were served individually directly from the kitchen which meant some people waited a long time for their meal. We were informed that usually meals were served from a trolley in the dining room which enhanced the dining experience. Meals looked appetising and people received support as needed.
● Where people consumed texture modified diets, advice had been sought from the speech and language therapist. For example, one person who was cared for in bed had a choking incident in January 2021 and a referral was made immediately for specialist advice on safe eating and drinking options.
● Kitchen staff were knowledgeable about people's eating and drinking preferences and needs. We saw the menu and any specific requests were discussed at a recent resident's meeting. This meant people's preferences could be included in the four weekly menu which was in place.
● There was one member of kitchen staff on duty each day. This meant there would be limited time available to accommodate individual requests for people who preferred a different meal option.

Adapting service, design, decoration to meet people's needs
● There was limited dementia friendly signage to assist people with orientation around the building. Some rooms had people's names and photographs on their doors and some didn't. It could be easy for staff to bypass someone's room without knowing there was anyone in it. A consistent approach would improve safety to people.
● A programme of redecoration was ongoing since the new provider acquired the service. Furniture and décor in communal areas had been refreshed, these areas were spacious and welcoming. We looked in all

bedrooms and saw these were suitable and personalised for people living in the service.

● Innovative ideas were seen in some areas of the service such as a bus stop near the front door. This was helpful for some people living with dementia who may want to leave the service at times. Staff were able to re-direct their attention to the bus stop, and we saw this was an area where people tended to congregate.

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

● At the time of inspection the provider was in the process of de-registering the nursing element of their care provision. Reviews were ongoing with local authority and health professionals to ensure everyone in the nursing unit was re-assessed appropriately.

● Staff worked closely with health and social care professionals to ensure people accessed the care and support they needed. A nurse practitioner visited the service to do a weekly ward round and we saw the service worked with other professionals such as the mental health in-reach team, speech and language team and DoLS team.

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 not inspected. This is the first inspection of this key question for this newly registered service. This key question has been rated as requires improvement.

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

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

- Staff did not have access to up to date care plans for the majority of people to inform them of people's needs and preferences. Staff relied upon their relationships with, and knowledge of, people to know the support required. For newer or agency staff this meant people may not receive consistent care in line with their preferences, particularly for people who could no longer verbalise their wishes.
- We saw people being offered choices throughout the day. People could choose where they wanted to spend their time and eat their meals. One person preferred to eat while they were moving around which staff supported.
- The deputy manager told us people had access to, and had used, advocacy support as needed. Advocates assist people communicate their wishes and are an independent service.

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

- Our observations throughout the inspection visit were of staff showing kindness and good care to people they supported. One person had a fall on the morning we arrived. Staff showed empathy and attentive support towards the person throughout both days of our inspection.
- Staff who had worked in the service for a while knew people well and had built positive professional relationships with them. We consistently heard staff speak warmly and positively to people when they were with them and about people when they were talking to colleagues.
- Relatives gave positive feedback about the care their loved ones received. One relative told us, "They are really settled, staff are lovely to them." Another said, "The care is great, they are really good to [relative]. There have been little disagreements, but they always sort it out."
- Where people's first language was not English, sometimes care staff were available who spoke the same first language. This ensured people were able to express themselves in their preferred language, but this did not happen for everyone.

Respecting and promoting people's privacy, dignity and independence

- We observed staff respecting people's privacy and dignity. Staff knocked on room doors before entering. We saw staff support a person who had been incontinent in the communal lounge discreetly and sensitively. They accompanied the person into the toilet and other staff members offered additional support without being prompted to do so.
- People's information was stored securely within the nurses station, and staff were aware of the importance of keeping people's personal information secure.

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 not inspected. This is the first inspection of this key question for this newly registered service. This key question has been rated as requires improvement.

This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

- Systems and processes were not in place for people and their loved ones to be involved in the care planning and review process. Regular reviews did not take place to review and update people's care plans. Although staff liaised with relatives there was no record of their participation in the development or the ongoing monitoring of people's care needs.
- Care records did not include confirmation of consent to the care plans by people or their representatives. This meant it was unknown if they agreed with the contents and people did not have choice and control in the planning of their care.
- We observed staff were busy and task focused at times rather than person centred in their approach to care.
- Processes to support DNACPR (Do Not Attempt Cardio Pulmonary Resuscitation) decisions and documentation required improvements. We found one person's form had not been signed by the clinician and another had the person's previous home address on it. A further care file had a front sheet stating there was no DNACPR in place but a DNACPR form had been completed in May 2020. These could lead to wrong decisions being made about whether a person should be resuscitated in the event of cardiac arrest. The provider confirmed an urgent review was underway.
- End of life care planning for people required improvements. One person was nearing end of life care and their care file contained scant information about their and their family's preferences. Other care files we reviewed also lacked detail. There was little evidence of meaningful discussions taking place with people or their loved ones about this important aspect of people's care planning.

The provider had not ensured people received personalised care which was appropriate, met their needs and reflected their preferences. These concerns constitute a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment.

- Staff had built positive relationships with people living in the service and knew their preferences well. This meant people received day to day care which was attuned to their care needs. Relatives were usually kept updated. One family member told us, "I ring once a week and ask for an update, no matter who they are, they are always willing to talk to you, it's a pleasant atmosphere when you walk in." We heard staff on the telephone giving relatives updates during our visit. Staff told us the new manager was making improvements and supporting the team to become more person centred. For example, not rushing all care tasks with people in the mornings as they could support people throughout the day if that was their

preference.
● The majority of staff had undertaken recent online training about end of life care. During the pandemic period it is more important than ever that staff are equipped and skilled in managing all aspects of end of life care for people living in the service.

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.
● The provider was aware of the Accessible Information Standard. We did not see examples of information in other formats to support people, such as large print or pictorial, but this could be available if requested.
● Some care files contained updated communication care plans which made reference to people's communication needs including their use of glasses and hearing aids. For example, one person's communication care plan said, "I have hearing aids but I don't wear them because I can hear well without them." We saw some staff wearing visors as well as face masks. When they talked to people with hearing difficulties staff stepped back and pulled down their mask so the person could understand what staff said. We observed this was effective in supporting people who needed it.
● One person was tearful when we spoke with them and their relative confirmed their sadness had emerged since the person began to live with dementia. We saw staff interacted positively and in a jovial way with them which was supportive but did not connect with how they were feeling. People did not have detailed plans or communication passports which set out how they were best able to express their views and feelings, which may not be verbally. Staff did not have guidance on how to connect and tune into people's emotional wellbeing and support them fully in this area.

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 gathered in several communal areas throughout the service but there were few meaningful activities available. A number of people were cared for in bed and were at risk of social isolation. An activities coordinator was due to commence the week following the inspection to develop and undertake activities for people to participate in.
● Hobbies and areas of interest were not always set out in people's care plans. Two of the files we looked at had a, 'This is Me' document in their care file which was blank. People were not always able to express their interests so this meant they could not be supported to do things they enjoyed and were beneficial for their mental wellbeing.
● People were supported to maintain relationships with their loved ones. Throughout our visit we saw staff supporting people have telephone or video calls with their relatives. We also saw window visits taking place. A comfortable visiting room was being prepared to facilitate indoor visits which have commenced since the inspection took place.
● Staff told us when it snowed recently, they brought some inside and built a snowman which people enjoyed. There was also a fox which visited the garden regularly and everyone enjoyed observing.

Improving care quality in response to complaints or concerns
● There was a complaints log which set out any concerns or complaints which had been raised. Further detail was needed so all information about the process and timescales, the actions taken, any investigation and outcome were clear.
● The service was going through a period of significant change with the removal of the nursing unit. This meant some people had moved rooms or were due to move out of the service. Some relatives had not had a

positive experience of this and did not believe this had been handled or communicated well.

● We received positive feedback from one relative who had raised a concern and felt it had been resolved promptly.

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 inspected but not rated. At this inspection this key question is now rated as inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- Systems to ensure health and safety issues were maintained and monitored were not effective. Actions to ensure the building was safe in the event of a fire were not undertaken within recommended timescales. This placed people at risk of physical harm.
- The provider did not have effective systems in place to assess, monitor and improve the quality of the service. Processes to maintain oversight of people's care including care plans and risk assessments, medicines, accidents, incidents and falls were not effective. This meant people were at risk of receiving unsafe care which did not meet their needs and of this not being identified and remedied.
- The systems in place to monitor the safe use of medicines in the nursing unit was not effective. Quality assurance checks had not picked up concerns about the storage, recording and administration of prescribed medicines including those administered 'as needed'. People were at higher risk of harm because of this.
- The provider did not have an effective system in place to monitor recording of people's care such as daily notes and monitoring charts. Charts contained gaps and were not used to inform daily practice. The provider had not identified the system of monitoring people's food and fluid intake was not working. Although a new system had recently been introduced it had not picked up the issues we found.
- Charts which were used to record incidents where people had shown distressed behaviours were not reviewed or analysed by management staff. This meant opportunities to review staff practice, understand people's needs better and improve their care were missed.
- There was no effective system in place to monitor care records to ensure any incidents of a safeguarding nature were responded to appropriately. The local authority were not always notified of all incidents where harm or potential abuse had taken place. This meant safeguarding professionals did not have all available information to effectively monitor the service and ensure people were protected from the risk of harm or abuse.
- Incomplete and inconsistent documentation for decisions around DNACPR had not been identified by the provider. An urgent review took place immediately following the inspection.
- It had not been identified until the comprehensive audit several days before the inspection took place there were either no or out of date mental capacity assessments in place. There was also no process for

making and recording best interests decisions when important decisions needed to be made on people's behalf when they were not able to make decisions for themselves. For example, the decision to live in the service, for staff to manage a person's money, participate in regular testing for COVID-19.
● The provider had not embedded a person-centred culture in the service. People and their relatives were not involved in regular reviews of people's care. There was no evidence in care records of people or their representatives consenting to care plans.
● Staff did not have access to the most up to date information about people's needs or preferences as the majority of care records were not up to date. This impacted upon the ability of staff to support people achieve good outcomes.

There was a lack of systems and processes in place to ensure effective management oversight and quality assurance of all aspects of people's care. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider's detailed audit had identified widespread shortfalls. Throughout the inspection the provider and management team were open and honest about the failings and were committed to making and embedding improvements.
● Positive feedback was received from staff about the commitment of the provider to make ongoing improvements to the service. The provider had faced difficulties in achieving this consistently due to a lack of registered manager for a sustained period of time. An operations director had been placed full time in the service to support the implementation of improvements.
● Although the provider submitted notifications to the CQC, we found not all notifiable incidents had been reported. This included incidents or allegations of abuse, and serious injuries.

This is a breach of Regulation 18 Notification of other incidents of the Care Quality Commission (Registration) Regulations 2009 (Part 4).

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
● Although the service had appointed a new manager in December 2020 they were absent at the time of inspection. Their application to become the registered manager had not been received by the CQC. The service had not had a registered manager since June 2020 although cover arrangements had always been in place. From the week of the inspection an operations director was based full time in the service to provide management support and oversight.
● The provider was aware of their responsibilities under the duty of candour to be open and honest when things went wrong. We could not be assured that discussions always took place with people and their relatives when incidents occurred due to the lack of effective recording and monitoring systems in place.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● A resident coffee morning and meeting had taken place several days before the inspection. Six people using the service had attended. A variety of topics had been discussed including meals, activities, quality of care and who to talk to if people had any concerns.
● Staff had a recent opportunity to share their feedback. We saw a staff survey had been undertaken at the end of 2020 and the results analysed in a report, 13 staff had responded with a range of views. The majority of staff felt management and the provider were supportive and the majority also felt people were safe and well cared for.
● The service worked in partnership with social care and health professionals involved in people's care.

Reviews were ongoing to ensure people were appropriately re-assessed in light of the imminent closure of the nursing unit.

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 9 HSCA RA Regulations 2014 Person-centred care Personalised care was not being provided to people in a way which was appropriate, met their needs and reflected their preferences. This included care planning and review, consent, DNACPR processes.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Timely action had not been taken following the last fire risk assessment. Risk assessments were not in place for known risks to people's health, welfare and safety. Medicines processes in the nursing unit were not always safe.

The enforcement action we took:

We issued a Warning Notice to give the provider a short period of time to implement improvements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Quality assurance systems were not effective in most areas of the service and there was a lack of management oversight of people's care and safety. There were ineffective systems in place to monitor the quality of care and drive improvements of the service.

The enforcement action we took:

We issued a Warning Notice to give the provider a short period of time to implement improvements.