Sundridge Developments Limited

Edenvale Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Edenvale Nursing Home is a care home that was providing personal and nursing care to 11 people at the time of the inspection. It is registered to provide a service to up to 35 older people who may be living with dementia, physical disability and mental health needs.

People's experience of using this service:
At our last inspection we found serious concerns. At this inspection we found that insufficient improvements had been made. The service remained unsafe at times and not well led.
Insufficient action had been taken to ensure that where people were at risk as a result of their conditions or the care they needed, the risks were assessed, understood and plans implemented to reduce these. This included not seeking expert support in a timely manner.
Processes to keep people safe from abuse were not operated effectively because internal reporting did not always take place appropriately. Recruitment practices did not ensure people were safe because the provider had not always ensured appropriate pre- employment checks were carried out. Feedback from people was that staffing levels and deployment did not meet their needs and we have made a recommendation about this.
Staff were on occasions, task focused, did not always respect people's dignity and people's preferences and wishes were not always known or detailed in care plans. Where they were recorded these were not always adhered to. There was a lack of evaluation of care, meaning concerns were not identified.
Systems had not been effective in identifying shortfalls and unsafe practices. Governance systems failed to identify people were not always treated with dignity, equality and respect. Insufficient action had been taken to address the poor culture in the home because leaders lacked an awareness of their responsibilities and of the concerns in the home. As a result, safe standards of care were not consistently delivered.

As insufficient improvements had been made the service remains rated overall Inadequate and will continue in special measures.

Rating at last inspection: Inadequate (Report published 28 May 2019)

Why we inspected: This location was rated as Inadequate following inspection in October 2018 and was placed in special measures. We urgently imposed conditions on the providers registration which meant they could not admit anyone into the home and which required them to undertaken certain governance processes and report to us monthly. This was a planned inspection to follow up on the previous rating of inadequate and check improvements had been made.

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

Follow up: We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received we may inspect sooner.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our Safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our Effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive

Details are in our Responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our Well-Led findings below

Edenvale 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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team: The inspection was carried out by two inspectors and an expert by experience. An expert by experience is someone who has personal or professional experience of this type of service.

Service and service type: The service is a 'care home'. People in care homes receive accommodation and nursing or personal care. The Care Quality Commission (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. This means that the provider was legally responsible for how the service is run and for the quality and safety of the care provided.

A new manager had been appointed and been in post approximately three weeks at the time of our inspection.

Notice of inspection: This inspection was unannounced.

What we did: To help us plan our inspection, we reviewed information we held about the service, including notifications. A notification is information about events that by law the registered manager should tell us about, for example, safeguarding concerns, serious injuries and deaths that have occurred at the service. During the inspection we spoke with six people, three relatives, eight members of staff including the new manager and clinical lead, the nominated individual and a representative for the provider.

During the inspection we spent time in communal lounges and the dining room. We completed a short observational framework for inspection (SOFI) during the lunchtime meal. This method of observation enables us to gain more of an insight into the experiences of those people who may not be able to verbalise their care experience to us.

We reviewed eight people's care records, medicines records, reviewed the providers recruitment process and checked a number of the providers policies and procedures relating to dignity and respect, staff training, support and supervision. We also looked at documents relating to the governance of the service.

Inadequate

Is the service safe?

Our findings

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

People were not safe and were at risk of avoidable harm. Some regulations were not met.

We received mixed feedback about whether people felt safe. Most people said they did, and relatives felt the same. One relative told us, "Oh yes I think so, he's had nothing untoward happen to him. However, one person said, "Yes from a physical point of view but not from a mental health point of view."

Whilst people and their relatives felt safe we found numerous concerns that demonstrated people were not in receipt of a safe service.

Assessing risk, safety monitoring and management:
• At the last inspection in October 2018 we found that people were at risk of avoidable harm because risks were not effectively assessed, and mitigation plans had not been clearly developed to reduce these. Staff did not ensure that equipment to improve safety was consistently in place. Staff did not always recognise physical deterioration in people and did not make appropriate referrals to other professionals in a timely manner.
These issues put people at risk of harm and was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• At this inspection sufficient improvement had not been made. Risks to people continued to be poorly assessed and managed. Mitigation plans had not been clearly developed and not all staff understood risks to people.
• Two members of staff we spoke with were unaware that one person was at risk of experiencing seizures and confirmed that they had not received training in management of seizures.
• One person had been assessed by an external professional as requiring a textured modified diet to reduce the risk of them coming to harm as a result of choking. The manager told us this person chose to eat items that placed them at risk and that a capacity assessment had determined they had capacity to make this decision and understand the risks this posed. However, we did not find any records reflecting the person understood the risk they were taking, and a care plan evaluation dated 18 March 2019 stated that they had limited awareness of risks and safety. In addition, there was no mitigation plan in place for the times when the person did choose to eat items that may place them at risk. We found a near miss incident had occurred prior to the inspection where a member of staff had given the person a food item which posed a risk, resulting in a choking episode and the need for first aid.
• Guidance from the external professional had not been accurately reflected in this person's care plan and was not followed. For example, the professional had stated this person was not to use a straw in drinks however, fluid records for 22 and 23 April 2019 suggest they were given this.
• On review of the training information for staff we found that only six of 29 staff providing direct care had completed training to support them to manage the risk of choking. Only 12 of 29 staff providing direct care had received first aid training. This meant the person was at significant risk of death as a result of choking.

• For another person we found they could also be at risk due to the lack of consistent information in their records about the level of thickened fluids they should be supported with.
• Staff told us the first person could be aggressive and the handover sheet confirmed this. However, no assessment of this risk to the person or others had been undertaken and no plan implemented to reduce this risk. For a third person we were informed that they had hit another person during our visit. This was a known behaviour, however no assessment of this risk to the person or others had been undertaken and no plan implemented to reduce this risk. Only eight of 39 staff who provided direct care had received training in challenging behaviour.
• This meant others may be at risk of harm from these behaviours and the person may receive support that was inappropriate to their needs.
• A fourth person's room contained suction equipment. Suction is a piece of medical equipment most commonly used to remove secretions from a person's airway where they are unable to do so for themselves. In some cases it is an invasive procedure which involves placing long tubing down a person airway while using the machine to suck secretions out. It is often an unpleasant experience for people. It is also a potentially a hazardous procedure and should therefore only be performed when there are clear indications for its use. A member of staff told us this was in place due to chest infections causing an increase in secretions because the person was living with Chronic obstructive pulmonary disease (COPD). However, the person's care records stated they were living with asthma and not COPD. There was no assessment to determine when this equipment would be used and how the person was to be monitored during and after its use. This meant the person could be placed at risk of receiving invasive treatment that was not appropriate.
• The Medicines & Healthcare products Regulatory Agency states that operators of any piece of medical equipment must be trained in its use and able to prove they are competent. However, the manager confirmed they had been unable to find any evidence nursing staff had been trained in the use of this or that they had been assessed as competent to use it. The nominated individual was also unable to confirm this had taken place.
• In addition, the suction catheter tubing attached to the machine had expired in January 2019 and the extra tubing stored underneath the suction machine had expired in 2015. The risk of using equipment that is out of date is that it may have become degraded and no longer be sterile, therefore posing a risk of infection. The clinical lead removed these and immediately ordered new stock. However, no one was able to explain why the equipment was out of date and still in place. The clinical lead implemented a checking system following our findings.
• This meant the person could be placed at risk of receiving invasive treatment that was not undertaken by competent staff and was not appropriate, or safe.
• People were placed at risk because when care plans were in place, they were not followed. In March 2019 a person sustained a minor injury above their eye because member of staff did not follow their care plan and rolled them in bed without a second member of staff. The person rolled too quickly onto the zip of the pillow.

A failure to ensure people received safe care and treatment, that risks to them were assessed, understood and plans developed to reduce the risk was an ongoing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong:
• Although staff told us discussion took place in handovers following incidents we were unable to see how lessons were learnt and how learning was used to make improvements. For example, no improvements to the risk assessment for the person at risk of choking had been made. Agency staff continued to support people at risk of choking with their meals, rather than the more experienced and permanent staff.

A failure to effectively analyse incidents to ensure lessons were learned and improvements were made was an ongoing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse:
• Appropriate systems were not operated to keep people safe and protect them from the risk of abuse.
• Two of three staff spoken with were unaware what was meant by the term safeguarding, however they were aware of the signs of abuse and said they wouldn't hesitate to report concerns. One member of staff told us of concerns they had and said they had reported this to the nurse in charge, however the manager and nominated individual were unaware of this concern until we spoke with them. The manager told us they would investigate this and report back to us and to the local authority. However, the failure on the nurse's behalf to report issues of a potential safeguarding nature appropriately demonstrated that not all staff working in the home understood their responsibility to keep people safe from harm.
• The service failed to ensure incidents that placed people at risk were appropriately reported. One person experienced a choking incident as a result of being given, by staff a food item that posed risks. The external authority responsible for this person's placement confirmed they had not been made aware of this incident until we reported it. A failure to effectively investigate this incident meant that measures to reduce the likelihood of reoccurrence had not been implemented.

The failure to operate effective systems and processes to prevent abuse was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment:
• Recruitment practices required improvement to ensure people were supported by staff who were safe and appropriate to do so. One member of staff told us they had started to work at Edenvale in September 2018 following an interview but had been told by the provider in December 2018 that the provider did not have a Disclosure or Barring Service (DBS) check for them. A DBS is a check of a person criminal background and safety to work with vulnerable adults.
The provider told us that this had been identified during an audit of staff files in December 2018 and that they immediately stopped the member of staff from working shift until the DBS was applied for and received in February 2019. • References had not always been sought in line with the providers own recruitment policy. The nominated individual confirmed to us that no references had been sought for the person who did not have a DBS before they started work and that it had been three months before this had been identified. This meant sufficient pre employment checks had not been carried out before this person was allowed to work with vulnerable adults. • The professional registration of nurses was not always checked by the provider prior to employing them. We found no check of a recently employed nurse's registration had been undertaken.

A failure to ensure safe recruitment practices were operated was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received consistent feedback from people that staffing levels were not sufficient to meet their needs. When asked if they felt there were enough staff, one person said, "I don't think so, we need more." A second person said, "Breakfast is 0830-1030. You don't ask for a commode when they are serving breakfast. You know you can't have one. They say you have to wait if you ask for one." A third person told us, "No definitely not" and a relative said, "There is supposed to be someone in the lounge at all times and most of the time there is."
We observed one person mobilising without any support from staff, despite being told they needed this. A staff member told us they were unsupported because they were the only staff member in the lounge and

couldn't leave the other people.
• One member of staff told us they did not feel there was always sufficient numbers of skilled staff on duty. They told us that a high number of agency staff were used in the home, mostly in the afternoons to late evening and that agency staff did not always have the knowledge of people that they needed to support them. We found an incident that occurred whereby a person experienced a choking episode and required first aid because an agency member of staff had given them an item to eat that was outside of previous specialist advice.
• Although we observed calls bells being responded to promptly during our inspection, we also observed occasions when people in the lounge where left without support.

We recommend the provider seek advice and guidance about systems to ensure staffing levels and deployment of staff meets people's needs.

Using medicines safely:
• At the last inspection in October 2018 we found that the management of medicines was not always safe. One person had not received vital medicines because the home had run out of stock. Guidance for staff on the use of medicines prescribed on an 'as required' (PRN) basis was not in place. Storage of medicines was not always safe because temperatures were inconsistently checked. Specialist pharmacy advise had not been sought for people receiving medicines covertly (without their knowledge). These issued put people at risk and were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
• Improvements to the management of medicines had been made and there was no longer a breach of this regulation. However, improvements were still required for the guidance. For example, one person prescribed a cleaning spray to be used at least daily had no records to confirm this had been used every day. For a second persons prescribed creams, there was no guidance to tell staff when these should be used, and records didn't confirm this was applied daily.
• Storage of medicines was safe. Medicines trolleys were locked in locked rooms. Temperatures of the medicines room and fridge were checked daily to ensure these remained at safe levels so as not to affect the medicines effectiveness.
• Creams, eye drops, and liquid medicines had the date they were opened recorded on them.
• Medication Administration Record (MAR) sheets contained information about people's allergies, the medicines they were prescribed, including photos of the tablets and well as a photo of the person. Stock received into the home was recorded to enable clear monitoring.
• Protocols were in place for the use of medication prescribed on an as required basis.

Preventing and controlling infection:
• Staff were observed to be using personal protective equipment, although we observed on one occasion a senior member of staff asked another why they were wearing the PPE used for personal care while walking through the home and remind them this was inappropriate.
• The home was clean and tidy throughout with no malodours present.

Inadequate

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

There were widespread and significant shortfalls in people's care, support and outcomes. Some regulations were not met.

Staff support: induction, training, skills and experience:
• When asked if people felt staff knew what they were doing one person told us, "No, they are not particularly good with the hoist and wheelchair." Whereas a second person told us they felt staff were "good".
• One member of staff told us their induction had been "poor". They told us they had been shown fire exits and where to find the care plans as well as spending a couple of days with a member of staff employed to manage quality. A second member of staff told us that despite starting work in September 2018 they did not receive an induction until February 2019. The provider was unable to provide us with evidence that staff had been inducted into the home as no records of this were available.
• One member of staff was administering medicines and told us they had not received any training in this since starting work in the home. The training matrix confirmed this. In addition, we found the training matrix reflected that a second nurse had also not received this training. The lead for quality for the provider told us nurses had received competency assessments for the administration of medicines, but the manager said they had not seen these. The provider was unable to show us evidence of these competency assessments.
• We identified significant gaps in the training that staff had received. Only 18 of 29 staff who provided direct care had received training in moving and handling. One member of staff told us about concerns they had about a staff member rough handling a service user using a piece of equipment to support a person to move. The training matrix showed the member of staff that the concerns were related to had not received this training. The training matrix showed that only 18 of 29 staff who provided direct care had received safeguarding training and we found that the reporting of safeguarding concerns was not always appropriate. The member of staff who reported the concerns to the nurse and not the manager had not received this training. Only seven of 29 staff had received training in person centred care and we identified concerns about the planning and delivery of individualised care.

A failure to ensure staff were appropriately inducted, trained and competent to carry out their roles effectively was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Best practice is that staff new to care are supported to undertake and complete the Care Certificate. This is an agreed set of standards that sets out the knowledge, skills and behaviours expected of staff in care-based roles. However, we found no evidence that one new member of staff who had not worked in care before had undertaken this. Following the inspection, the nominated individual sent us a copy of a certificate showing this person had completed this.
• Staff told us that they felt supported in the home. Supervisions had started to take place and most staff had received one in the last month. However, prior to this the records showed these had been inconsistent.

The manager told us they intended to ensure these were completed at least two monthly and had a matrix to ensure people knew who was responsible for carrying these out.

Supporting people to eat and drink enough to maintain a balanced diet:
• Eating and drinking care plans were in place but lacked person-centred guidance about people's nutritional and hydration needs and how they would be effectively met.
• One person's body mass index indicated they were underweight. A care plan was in place which stated they should be provided with three fortified drinks a day however; food and fluid charts did not reflect this was given and a member of staff told us this person did not have a fortified diet or drink the fortified milkshakes. The care plan also stated that they should be offered snacks between meals, but food charts did not consistently reflect this and showed a poor dietary intake and no encouragement provided.
• In addition, this person's care plan suggested they should be encouraged to drink approximately 1200 – 1400mls per day. However, records showed that this amount was not being offered and the person was regularly drinking a significantly less that the care plan suggested. For example, on 19 April 2019 records suggested this person was offered a total of 450mls in 24 hours and drank 50mls of this. Nurse evaluation of this was poor. There was no evidence that nursing staff, or any other staff was evaluating this person's food or fluid intake or taking action to address potential malnutrition and dehydration concerns.
• We found similar concerns for another person whose weight was low and fluid intake was poor. However, there was no evidence of action taken to manage this.

A failure to ensure that risks associated with people's care were adequately managed was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to live healthier lives, access healthcare services and support
• At times people were supported to access other health care professionals and records showed involvement of GP's and others.
• However, it was not always evident that staff acted promptly and made referrals in a timely manner to ensure people received appropriate advice and support. For example, for one person who had consistently lost weight, no referral had been made for dietician input. For a second person whose weight was low and fluid intake was poor, we found no evidence of discussions about this taking place with their GP.

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 with appropriate legal authority. 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, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

• Throughout the inspection we observed staff seeking people's consent before providing support. However, it was not always clear from the records that it was understood who could provide consent. For example, we were told of one person who had capacity to make their decision, but their family member had signed a consent form for the use of photos in their care plan and medicines records. There was no information to

state why this family member had been asked to provide consent when we were told the person was able to give this themselves.
• Although staff spoken with demonstrated a good understanding of the principles of the MCA, this understanding was not reflected in their records. For example, one person had a capacity assessment which determined they lacked capacity to consent to care and treatment. Mental Capacity assessments must be decision and time specific and therefore considering this for consent to care and treatment is not decision or time specific.
• However other assessments were more specific and showed that others had been involved in best interest decision making. For example, a second person's capacity assessment demonstrated they lacked capacity to consent to a specific diet texture and thickened fluids and their family member had been involved in the final decision to provide this.
• For those people who the service had applied for a DoLS authorisation, their capacity had been assessed, appropriate DoLS referrals made and we found no one had conditions associated with their DoLS.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Following our last inspection, we imposed a condition on the provider which meant they were not allowed to admit anyone into the home. As such no one had been admitted since the last inspection. A system was in place to undertake preadmission assessments before people moved in and these looked at people's needs in relation to their physical and social support.
• The service sought information about people's needs, likes, dislikes and life history. The Equalities Act 2010 is designed to ensure people's diverse needs in relation to disability, gender, marital status, race, religion and sexual orientation are met. It was not evident through the pre-admission assessment that all people's preferences and choices regarding some of these characteristics had been explored with people or had been documented in their care plans. For example, people's sexual orientation was not asked about. However, we saw no evidence that anyone who used the service was discriminated against and no one told us anything to contradict this.

Adapting service, design, decoration to meet people's needs:
• While not entirely maintained in a person centred style some efforts had been made to ensure the environment met people's needs but more work could be done to develop this further. Flooring helped to reduce the risk of falls and communal areas were well lit. There was some directional signage, bedrooms were numbered, and some included a picture of the person and their name.

Inadequate

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

People were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls and some regulations were not met.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence:
At our last inspection we found a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014 because people were not treated with dignity and respect. At this inspection we found insufficient improvements had been made.
• Although we did see a number of kind interactions by some individual staff, we found no evidence of any action the provider had taken to address this concern since our last inspection.
• We received mixed feedback from people about the support they received. One person told us, "I don't think I cause them problems, but they treat me with disdain. They don't clean my teeth properly." A second person told us, "Quite a lot of agency staff don't speak English in front of me. Makes me feel as if they're plotting against you." Whereas relatives told us, "The activities coordinator is wonderful, they're all nice girls" and "They are lovely, but not many regular ones left. Everyone seems very nice. I can't complain about them."
• On one occasion we observed a person being supported to move from one area of the home to another. This was carried out in an undignified and disrespectful manner because the person was put at risk of being exposed. We addressed this immediately and the clinical lead took action. However, they told us that this person had been moved throughout the building because staff said they did not have a "changing mat." The approach staff had taken was task focused and not based on ensuring this person's dignity was maintained.
• On another occasion, the manager told us that one person had asked if they "could die today". The manager told us they had responded by saying, "I said not today please." This comment from the person had not been explored and had been disregarded by the manager. We advised the clinical lead who told us they had not been informed of this and would contact the person's GP. The approach of the manager demonstrated a lack of awareness of the need to ensure this person's dignity was maintained, and their comments respected and treated with seriousness.
• On other occasions we heard staff using task focused language that did not demonstrate respect towards people. One member of staff was heard to say, "We do the assists first." They were referring to people who required physical support to eat their meals. We observed one person waited 30 minutes longer than others for their meal and when we asked a member of staff why they said they, "Do the pureed's first and then the normal."

A failure to treat people with dignity and respect was an ongoing breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to express their views and be involved in making decisions about their care:
• There was some evidence in care plans of family involvement. Two relatives told us, "I went through the care plan with the previous clinical lead" and, "Yes and I sign it but I think the new manager is going to do a new one."
• Although we saw relative meetings were taking place and relatives were able to make suggestions, we found no evidence that meetings with people were taking place.

We recommend the provider seek advice and guidance from a reputable source about involving people in decisions about the care.

Requires Improvement

Is the service responsive?

Our findings

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

People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control; End of life care and support

• It was not always evident how the service was responsive to people's needs.
• For example, the manager told us that one person had asked if they "could die today" and the manager had responded by saying "not today please". We were told this person suffered with depression, but this comment had not been explored further with them. We spoke to the person who was feeling "fed up" because of a health issue they could not control. We asked if they had been seen by the GP recently regarding this and they said they had not. We informed the clinical lead who told us they had not been aware of this person's comment and told us they would ask the person's GP to review them. No care plan or guidance was in place to identify how staff should support this person who was known to experience episodes of low mood.
• When care had been planned it was not consistently provided to people.
• For example, for a second person who was living with severe contractures of their limbs, we saw they had been seen by an external professional and guidance had been provided for staff to follow to help prevent the contractures from worsening. This included regular support to reposition themself and guidance about the length of time the person should be sat in a chair. Records confirmed the care plan for this person was not being consistently adhered to. For example, we found entries which showed they had been sat in a chair for up to five and a half hours, when it was planned that this would be no longer than two hours. In addition, when in bed the records showed occasions when the person was not repositioned for up to four and a half hours during the day and six hours at night, when they should have been supported to change position two hourly during the day and four hourly at night. There were no records to reflect that the information gathered was evaluated by nursing staff and used to ensure people were receiving the support they needed. On the day of our inspection we observed this person was seated in a chair for three and a half hours. A member of staff said since the paperwork had changed the times were no longer recorded meaning that staff did not always remember the time.
•Care plans lacked information about people's preferences, likes and dislikes. Whilst permanent staff appeared to know this information, the service was using a high number of agency staff who did not.
• We found an occasion had occurred with one person who had expressed a preference to be supported by female staff only. However, received the support from a male agency worker, meaning the staff member was either not made aware of their preference or chose to disregard this.
• No one was receiving end of life care at the time of our inspection.
• Only one member of staff had received training to support end of life care.
• Plans to support people at the end of their life were poor and contained no information that would guide staff to their needs, wants and preferences.
•The clinical lead told us they were aware this needed to be improved upon and would be working on these.

A failure to ensure care was planned and delivered to meet individual needs and preferences was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns:

● A complaints procedure was available for all to view in communal areas. It contained information about how and to whom people and representatives should make a formal complaint to. There were also contact details for external agencies, such as the Local Government Ombudsman. Records demonstrated complaints had been investigated and responded to appropriately.

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

There continued to be widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Leadership and management; Understanding quality performance, duty of candour responsibility; Continuous learning and improving care:

• Since our last inspection, the registered manager and clinical lead were no longer employed to work at the home. Between this time and our inspection there had been multiple changes in the management of the home. One staff member told us they, "Have had three managers and two clinical leads in really short time." They said "Things are always changing. Paperwork changes and moves, then you can't find something that you need. There is too much change and its not been communicated well." At the time of the inspection a new manager was in post and had started approximately three weeks before our visit. However, three weeks following our inspection visit they resigned from the position and left with immediate effect.

• Leaders lacked an awareness of their responsibility. The nominated individual (NI) was unable to tell us what was meant by Duty of Candour and when we asked them if they had a copy of the regulations they were required to meet, they said "no".

• The NI told us the quality focus has been on training and governance structures and that they had looked at some of the care records, however the gaps in the training, the lack of awareness of the poor risk assessment and management, lack of dignity and respect shown by staff demonstrated that this focus had been ineffective. The new manager told us that the NI "needs managing".

• At our inspection in October 2018 we rated the service inadequate and identified multiple breaches of the regulations which meant people's care and safety was compromised. Following the inspection, we took urgent enforcement action and imposed a condition on the provider's registration. Part of this condition required the provider to implement and use systems to monitor the service and to provide us with a monthly report. The aim of this condition was to support the provider to improve their governance processes, and in turn the quality and safety of the service. This had not been successful, and we continued to find multiple and ongoing breaches of regulations, and a service that was unsafe and not well led. Little action had been taken to address the concerns we found at our previous inspection in October 2018 and the nominated individual lacked an awareness of the concerns we found in the service during this inspection.

• Although monthly evaluation of care plans took place these were ineffective and demonstrated a lack of effective evaluation. For example, one person whose weight was a concern and their food and fluid intake were poor, the monthly evaluation had not identified this. It had failed to identify a choking incident and lack of sufficient risk assessment to guide staff. Where individual care plan audits had been completed these had been ineffective in identifying issues that required improvement. For example, these did not look at evaluating daily monitoring such as food and fluid intake as well as repositioning. The individual food and fluid and repositioning records were not being evaluated and as such concerns were not being identified and addressed. One member of staff told us, "We don't have enough competent staff." They told us they were frustrated that nursing staff were not taking accountability for poor practice, were set in their ways and

not responding to direction from the new clinical lead.
• A member of the providers management team was conducting quality audits in the service, but we were not always confident these were always effective in identify concerns. For example, the visit in February 2019 recorded that "Care Plans are concise, easy to read and audit." However, they had failed to identify a lack of person-centred information and a lack of detail about certain risks to people and the plans to mitigate these risks.
• This audit had also been unsuccessful in driving prompt improvement. For example, these identified the need for improved end of life care plans to be implemented. However, 10 weeks after this audit we found end of life care plans were poor and contained no information about the support people wanted at this time of their life. This report also highlighted a need to improve on the recruitment records for staff because these did not have all the correct documentation. However, 10 weeks following this audit we continued to find concerns regarding the recruitment records for staff.
• At this inspection the NI told us that they had felt that previously their auditing had not been strong and that as a result of our inspection in October 2018 they had learnt that they needed to "check evidence." We were not confident that the information provided to us in the monthly reports, submitted by the NI were always accurate, that the auditing processes to inform the reports was effective or that the NI had checked the evidence when compiling the report.
• For example, the report we received from the NI at the end of March 2019 told us that "16 out of 16 care plans have been fully reviewed (including all risk assessments) and updated. 27/02/2018 Action Complete." However, we found multiple concerns regarding the assessment and management of risk which we have reported under the Safe question.
• This report also stated that competency assessments for nurses, including agency nurses had been undertake in relation to clinical observations. However, when we asked to see competency assessment the NI was not aware of where these were kept and couldn't find them, the new manager told us they had not seen these. This also said that a full induction for staff was to be given and had been signed off as completed. However, at the inspection, we found no evidence that an induction had been provided to some staff. We requested the NI send this to us, but we never received this. This meant systems had not been effective in identifying shortfalls and unsafe practices. Governance systems failed to identify people were not always treated with dignity, equality and respect. The provider failed to create a person-centred culture within the home. As a result, safe standards of care were not consistently delivered.

The failure to ensure effective systems and processes were established to monitor and assess the safety and quality of the service, drive improvement and maintain records securely was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Planning and promoting person-centred, high-quality care and support with openness;

• At the last inspection there was a negative, task focused culture in the service. Whist one member of staff told us they felt, "Care has improved, and staff are now having more discussions about being more person centred" another also said, "I'm fed up of someone saying I'm just an agency nurse."
• Whilst we observed some kind interactions between some staff and people, we also observed some practice that showed disregard for people and was not person centred. We have reported this under the Caring question.
• Despite CQC identifying a breach of the regulation regarding dignity and respect at our inspection in October 2018, the provider had taken no action to address this concern. They had failed to ensure that staff had received training in this and only made this training mandatory after the April 2019 inspection, when we again found that people were not consistently treated with dignity and respect.

Working in partnership with others

• The service had been working alongside the local authority and the clinical commissioning team since before our inspection in October 2018. However, due to the ongoing concerns we found and the ongoing and new breaches of regulations we identified, we could not see how they were using this to help improve their service for people.