Parkcare Homes Limited

# Claremount House

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

Claremount House is a residential care home providing personal and nursing care for up to 26 people. At the time of the inspection there were 26 people in the home, some of whom were aged over 65 years and were living with a diagnosis of dementia, and others who were younger and had mental health needs. The home is purpose built with bedrooms located over three floors and communal areas on the ground floor.

People's experience of using this service and what we found
People were not safe. There were not enough staff to give people the care and support they needed or to keep the home clean. Standards of cleanliness were poor and infection control procedures were not followed.
People were not protected from abuse; some people were subject to inappropriate restraint due to environmental restrictions that were in place. Risks were not assessed or managed appropriately. Lessons were not learned when things went wrong. Medicines were not managed safely.

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. Staff did not receive the induction and training they needed to equip them with the skills and competencies to do their job. Some staff had received supervision but others had not. Complaint records for 2019 were missing.

Staff were recruited safely and people's healthcare needs were met.

People's nutritional needs were not met. People and relatives said they liked the staff. However, there were inconsistencies in staff practices resultant from a poor culture which meant people were not always well treated. Some staff were kind and caring, whereas others were not. People's privacy and dignity was not maintained.

People did not receive person-centred care and care records did not fully reflect their needs. There was a lack of activities for people and those who should have had one-to-one time with staff did not receive it.

The service was not well-led. Leadership was poor and ineffective; staff lacked direction and support and were left to their own devices. Many of the staff who knew people well had left and the high use of new and agency staff, who were not familiar with people's needs, had impacted negatively on the service. The provider's quality assurance systems were not effective in identify and addressing issues. The service has a history of not sustaining improvements.

Following this inspection we contacted the infection control team and fire authority to make them aware of our concerns. We made referrals to the local authority safeguarding team and informed the commissioners from the local authority and clinical commissioning group (CCG) of our findings. We had discussions with the nominated individual to gain assurances about the immediate actions they were taking to address the

issues we found. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

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

Rating at last inspection
The last rating for this service was Good (published 11 April 2017).

Why we inspected
The inspection was prompted in part by a specific incident and other concerns. The specific related to unsafe moving and handling. This incident is subject to a criminal investigation. As a result, this inspection did not examine the circumstances of the incident. The concerns we received related to infection control, wound care management, staffing and management of the service. A decision was made for us to inspect and examine those risks.

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

Enforcement
We have identified 9 breaches in relation to safe care and treatment, staffing, safeguarding people, complaints, consent, dignity and respect, nutrition, person centred care and governance at this inspection.

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

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

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

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

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

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

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?**

Inadequate

The service was not 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.

# Claremount House

**Detailed findings**

## Background to this inspection

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

Inspection team
On 8 July 2019 two inspectors and an Expert by Experience carried out the inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. On 23 July 2019 three inspectors and a specialist professional advisor in medicines returned to complete the inspection.

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

Up until May 2019 the service had a manager who was registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager left in May 2019 and there was an acting manager in post who was present on both days of the inspection.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. 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. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection-
We spoke with eight people who used the service and five relatives/friends about their experience of the care provided. We spoke with 14 members of staff including nurses, care staff, a domestic, the cook, the activity organiser and the manager. Seniors managers were present on both days of the inspection and for feedback at the end of the inspection; these included two quality improvement leads, the managing director, the assistant director of quality and governance and the operations director.

We reviewed a range of records. This included five people's care records and multiple medication records. We looked at three staff files in relation to recruitment. A variety of records relating to the management of the service were reviewed.

After the inspection –
The provider sent through the training matrix, maintenance records, incident reports and quality assurance records.

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 Good. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- Risks to people were not assessed or managed appropriately placing them at risk of harm or injury. Staff were unaware of risks to individuals and failed to keep people safe.
- Staff did not follow safe practices when moving and handling people and did not use the equipment people required. On three separate occasions we saw staff transferring one person without using the hoist which their care plan stated they required for all transfers. We saw staff hoisted another person in a sling which was too big for them. Staff could not locate the correct sized sling for this person.
- Pressure relieving equipment was not used safely or appropriately placing people at risk of skin damage. Two people were sat for several hours without the pressure relieving cushions they required. Other people's pressure relieving mattresses were not at the correct setting for their weight which placed them at risk of skin damage.
- Contradictory information about dietary requirements meant people who were at risk of choking did not always receive the type of diet they required. One person, who had experienced a serious choking incident in June 2019, had continued to be given food by staff which was not suitable placing the person at further risk of choking.
- Staff had not recognised the risks to people who were sat outside in direct sunlight and exposed to unusually high temperatures. Although one staff member was applying suncream to people, there were no parasols or hats to provide any shade. One person who was unable to move themselves had been placed in direct sunlight. They were moved to a shaded area when we raised concerns and hats and parasols were then provided for other people.
- Fire safety was not robust. Some but not all staff had completed fire safety training. Two fire drills had taken place in 2019 however many of the staff who had taken part no longer worked in the home. There were no systems in place to make sure all staff working in the home had received fire safety training and knew what to do in the event of a fire.
- Some people's bedroom doors were locked when they were in their rooms. Although the doors could be unlocked from the inside by people pressing down on the door handle, there were three people who were immobile and nursed in bed who would not have been able to open the door themselves. The manager told us all staff had keys to the rooms, however we found this was not the case.

People were placed at risk of harm due to poor risk management. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Because of the level of the concerns we asked the provider to respond to us and they confirmed actions had and were being taken to ensure risks described above were assessed and managed. They confirmed fire drills were being held with staff.

● Checks of the building and equipment safety were completed and recorded.

Systems and processes to safeguard people from the risk of abuse

● People were not protected from the risk of abuse as effective systems and processes were not in place. The majority of staff had received safeguarding training yet they did not always recognise or respond appropriately to suspected or actual abuse.

● We saw one person hitting another repeatedly in a communal area, three staff were present but took no action until we asked them to intervene. The nurse came to check both people; neither had sustained any injuries. When we asked the nurse if they would be reporting this incident to safeguarding; they said they only reported incidents that had been unwitnessed.

● Another person's daily records showed in May 2019 they had raised concerns with staff which indicated they may have been abused. The record showed staff had reported this to the manager. Our discussions with a senior manager indicated no action had been taken to investigate these concerns.

● One person was segregated to a specific area of the home where their bedroom was located and there were no communal areas. The person could not leave the area as there were keypad locks on the doors at either end of the corridor. The manager told us this was due to behaviours the person displayed which put other people at risk of harm or injury. Staff confirmed the person did not leave this area even though the person's care plan showed they should be supported to go out as much as possible.

● Other people were locked in their bedrooms when they were in them, to prevent other people going in.

People were inappropriately restrained and were not protected from the risk of abuse. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Because of the level of the concerns we asked the provider to respond to us and they confirmed actions had and were being taken, in respect of the risks described above, to ensure people were not inappropriately restrained and were protected from abuse.

Staffing and recruitment

● There were insufficient staff with the appropriate skills and knowledge to meet people's needs and keep them safe.

● The layout of the building and complexity of people's needs had not been fully considered when determining staffing levels. The manager told us they had identified staff were required for a twilight shift, however this extra staffing had not been provided.

● Staff were not always aware of people's needs. On the second day of the inspection two additional staff had been brought in to care for people in one of the communal areas. Both staff told us they did not know what they were doing and had not been given any information about people's needs or risks.

● We observed people in communal areas were often left unattended. When staff were present, they lacked awareness of how to keep people safe. For example, one person was sat on the very edge of their seat, they were unsteady and looked as if they were about to fall, a staff member was present but failed to act until we asked them to intervene.

● The manager told us there had been a high turnover of staff since May 2019 and there was an ongoing recruitment programme. Agency nurses and care staff had been brought in to cover these vacancies. Relatives raised issues about the high use of agency staff and lack of regular care staff.

The lack of sufficient, competent staff meant people were not safe. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Because of the level of the concerns we asked the provider to respond to us and they confirmed actions had and were being taken, in respect of the risks described above, to increase staffing levels and ensure the competency and skills of staff.

● Recruitment processes were safe with all required checks completed before new staff started employment.

Using medicines safely
● Medicines management was not safe.
● Medicines were not stored safely and securely. Medicine keys were kept on a key ring with other keys which meant the nurse was interrupted on a regular basis to open doors and provide access to rooms.
● On the first day of the inspection the nurse left the medicines room open and unattended. One the second day the medicines fridge was unlocked. Gaps in fridge temperatures records meant we could not be sure the fridge had always been at the correct temperature.
● Prior to the second day of inspection there had been a controlled drug incident which had been reported to the police and safeguarding. Following this incident, we found controlled drugs were being stored in a normal medicine cabinet and the keys to the cabinet were on the main key ring. This meant that we could not be assured medicines were being stored securely or in compliance with the Misuse of Drugs (Safe Custody) Regulations 1973 as amended.
● There were gaps on some medicine administration records which meant we could not establish if people had received their medicines as prescribed. Where people were prescribed 'as required' medicines, there were not always protocols in place to guide staff.
● Medicines policies and procedures had not been updated to reflect the reclassification of one medicine to a controlled drug and there was no extra guidance for another medicine which required close monitoring. Staff were not aware that one medicine could cause a skin reaction if the person did not wear sunscreen despite this being stated on the dispensing label.
● The nurse did not wear a 'do not disturb' tabard whilst completing the medicines round and was interrupted several times by both people living in the home and staff. Tabards were sourced during the inspection to help address this issue.
● Records for people who received their medicines covertly (hidden in food or drink) were not accurate or up to date.

Medicine management systems were not always safe which place people were placed at risk of harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Because of the level of the concerns we asked the provider to respond to us and they confirmed actions had and were being taken, in respect of the risks described above, to ensure medicines were managed safely.

Preventing and controlling infection
● People were not protected against infection as systems in place to prevent and control infection were ineffective.
● On the first day of the inspection we found the home was not clean, there were a large number of flies present and there were strong malodours in certain areas. We made a referral to the infection control team. The provider took action to improve the cleanliness of the building and when we visited on the second day we found the home was cleaner, the malodours had reduced and there were fewer flies.
● There were no effective systems in place to ensure good standards of cleanliness were maintained. On the second day of the inspection we saw cleaning staff were not following correct infection control procedures.

There were insufficient cleaning staff deployed although the manager told us they were recruiting new staff.
● Following the inspection, the infection control team carried out an audit at the home and made several recommendations.

Infection prevention and control systems were ineffective placing people at risk of infection and ill health. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Because of the level of the concerns we asked the provider to respond to us and they confirmed actions had and were being taken, in respect of the risks described above, to ensure the home was kept clean and infection control systems were effective.

Learning lessons when things go wrong
● Lessons were not learnt when things went wrong. An incident in December 2018 had raised concerns about staff moving and handling practices. We were assured at the time that lessons had been learnt and actions had been taken to prevent a recurrence. However, at this inspection we identified issues with moving and handling practices.
● A recent incident concerning controlled drugs had related to the safety and security of medicine keys. There had been no learning from this incident or action taken to ensure the keys were kept securely.

The provider failed to learn lesson when things went wrong placing people at risk of harm or injury. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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

- People were not supported to eat and drink enough.
- On both days of the inspection we saw people who did not receive any food or drink for several hours. One person was asleep in their chair from 9.30am until 1.15pm and had received nothing to eat or drink. Staff said they had offered but the person wanted to remain asleep. There were no records to show the person had been offered anything.
- The cook told us people could have what they wanted for breakfast including a cooked option. However, staff did not offer people a choice and everyone was given porridge and/or toast. There were no systems in place to make sure everyone had had breakfast. Staff did not know who had been given breakfast and records were incomplete. The cook said people often missed breakfast.
- At lunch time people were offered a choice but not given time to respond. A staff member took plates with sample meals to show people. Two people were asleep when the plates were put in front of them and the staff member said, "Which one? Pick. Which do you want?" People were not given time to wake up, understand what was happening or process the information being given. When one person tried to make a choice by reaching for a plate, the staff member pulled it back and said they needed to bring a fresh one. The person did not understand and held the plate, but the staff member continued to pull it back, saying, "You can't have this one, no."
- Jugs of juice and glasses were available in communal areas and some snacks were left out in the dining room. However, staff were not pro-active in offering these to people. One staff member told us morning drinks rounds often did not happen as staff were too busy.
- There were no menus displayed. Our discussions with the cook showed they lacked knowledge and understanding of people's dietary needs.
- Food and fluid charts were not completed correctly and were not monitored by senior staff to make sure people were having enough to eat and drink.

People were not supported to have enough to eat and drink. This was a breach of Regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Because of the level of the concerns we asked the provider to respond to us and they confirmed actions had and were being taken, in respect of the risks described above, to ensure people received the correct diet and had enough to eat and drink.

● Some people told us they liked the food. On the second day of the inspection we saw people in the garden were offered ice lollies and drinks in the afternoon.

Staff support: induction, training, skills and experience
● Staff had not always received the induction, training and support they required to carry out their roles.
● The training matrix showed a number of staff had failed to complete online training courses. For example, seven out of 28 staff listed had failed to complete fire safety training and eight staff had not complete infection control training.
● Some people living in the home had complex mental health needs and others were living with dementia. The training matrix showed specialist training was available in dementia care and managing behaviours that challenge others. However, only seven staff had completed the managing challenging behaviours training and only six had completed dementia training.
● New staff were not provided with a thorough induction or the support they required. One staff member, who had no previous care experience and had only worked four shifts in the home, was left alone in a communal area to care for people who were visibly distressed and agitated. The training matrix showed the only training this staff member had completed was online training in COSHH, Deprivation of Liberty Safeguards, the equality act, food safety and IT security.
● Staff were not receiving regular supervision. The manager told us they had completed supervision with one staff member and were in the process of arranging supervisions for all staff. The supervision matrix showed no staff had received supervision in April, May or June 2019.

The lack of effective training and support meant staff were not enabled to carry out their role competently. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Because of the level of the concerns we asked the provider to respond to us and they confirmed actions had and were being taken in respect of the risks described above to ensure staff had the required knowledge and skills for their roles.

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 were not supported appropriately to have choice and control of their lives because the key principles of the MCA were not always applied.
● The manager had a list of who had a DoLS authorisation in place. However, staff we spoke with did not know which people had a DoLS. Two people had conditions on their DoLS authorisation. The condition had been met for one person but not the other.
● One person's care records showed they had appointed someone to make decisions on their behalf through a lasting power of attorney (LPA). There are two types of LPA; one for health and welfare and the other for property and financial affairs. There were no legal documents to confirm the type of LPA that was

in place. The manager did not know who had LPAs in place and said they were in the process of sending out letters to relatives asking for this information.
● Mental capacity assessments and best interest decisions were recorded. However, these were not always completed correctly.

There was a lack of effective systems to ensure the principles of the MCA were followed. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Because of the level of the concerns we asked the provider to respond to us and they confirmed actions had and were being taken, in respect of the risks described above, to ensure the key principles of the MCA were met.

Adapting service, design, decoration to meet people's needs
● The physical environment was not adapted, designed or decorated to improve people's quality of life and promote their wellbeing. Keypad locks were fitted to most of the internal doors in corridors restricting people's movement around the home.
● There was limited signage to help people find their way around. Some people's bedroom doors had numbers and their names on, others had nothing to identify their room.
● Communal areas were sparsely furnished with little to occupy and interest people other than the television. Menu boards were displayed but not completed, clocks were set to the wrong time.
● Some bedrooms were personalised, although the majority were bare, with few personal effects. The manager told us there were plans in place to refurbish the home but did not know when this would happen. Decorators were in the home on the second day of the inspection.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were assessed before they moved in to make sure the service was suitable for them.
● People's care and support needs were assessed and recorded. However, records we reviewed did not accurately reflect people's current needs and preferences.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Staff did not work effectively as a team. Staff did not know where other members of staff were and did not communicate effectively to meet people's needs.
● People's care records showed health and social care professionals had been involved in people's care. This included GPs, community matrons, the mental health team and opticians.

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.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

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

- People were not consistently well treated and supported by staff.
- Some people told us they liked the staff describing them as 'lovely' and 'very nice'. Relatives said the staff were good.
- There were stark contrasts in how staff interacted with people. For example, one person was supported with their lunch and staff were attentive and respectful. Yet, another person was supported to eat porridge whilst they stood up and staff did not interact with them at all.
- Some staff were kind and compassionate with people. A staff member reassured one person who was crying and distracted them by going for a walk. Another staff member gathered a small group of people together and tried to engage them in a conversation about holidays.
- However, not all of staff understood people's needs or how to communicate effectively. One person was visibly anxious and screamed frequently. Staff did not respond and merely looked on without any attempt to engage the person. Another person was asking repeatedly for their breakfast, several staff walked past and ignored them. The person received their breakfast when one of the inspection team went to get this for them.

Respecting and promoting people's privacy, dignity and independence

- People's privacy and dignity was not promoted or maintained.
- People looked unkempt because staff had not supported their personal care needs. Men were not supported to shave, people's hair was not brushed, some people wore stained clothing, some people had no slippers or shoes on. One person was wearing trousers that were too big for them and each time they stood up in the lounge their trousers fell down. Staff were present but took no action to change the person's trousers until we asked them to do so.
- One person who was requiring support had urinated on the floor in the dining room and there was a delay in cleaning this up. Staff proceeded to serve breakfast to a person who was present when this had happened and was then expected to eat their breakfast with a pool of urine only a few feet away.
- Staff did not always knock on people's doors or consult people in their care. Some people in wheelchairs were wheeled out of the room without staff discussing where they would be going or whether they wanted to leave the room.

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

- People's views were not sought and there was little evidence to show people were involved in decisions about their care.

● One person told us their views were ignored and said they did not enjoy living at the home. They said they did not have opportunities to go out since the previous activities staff had left. A staff member said to the person, "You go out sometimes, don't you?" to which the person replied, "When staff can be bothered, which is hardly ever."

People were not always treated with compassion and their privacy and dignity was not respected. This was a breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Because of the level of the concerns we asked the provider to respond to us and they confirmed actions had and were being taken, in respect of the risks described above, to ensure staff treated people with care and compassion and maintained people's privacy and dignity in line with their basic human rights.

Inadequate

# Is the service responsive?

## Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant services were not planned or delivered in ways that met people's needs.

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

- People did not receive person-centred care. People's care records were not up to date and did not reflect their individual care needs or preferences. One person told us, "I do not get the care I need."
- One person's care plan stated they required a hoist and sling for all transfers. There was no information to show which hoist or the type or size of sling to be used. There was contradictory information about the type of diet this person required; one section showed they had a pureed diet while another stated they needed a fork mashable diet.
- Where people's care plans did contain guidance for staff this was not always followed. One person's care plan stated they should be checked by staff every 30 minutes and to record any behaviour displayed that challenged others. These records were not completed. Another person's pressure ulcer had not been redressed for several days and there was no current wound treatment plan in place.
- Staff told us they did not have time to look at the care plans. On the second day of the inspection the manager told us they had put one page profiles in place providing staff with a summary of people's individual needs. We found these were not accurate. For example, one person's profile did not show they had a DoLS in place, the profile for another person did not show the person had seizures.
- Three people were receiving end of life care. We looked at the end of life care plan for one person which was not person-centred and gave no information about the person's preferences or wishes.

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 were not supported by staff to pursue their interests or take part in activities they enjoyed.
- The home employed an activity organiser who said they usually worked weekends and were developing ideas for different activities. On the first day of the inspection this staff member was working as a cleaner. On the second day they had been asked to come in so they could sit outside with people in the garden.
- A timetable of daily activities was displayed in the reception area, however, none of these took place. People spent long periods of time sitting passively, looking anxious or walking round. Staff made very little attempt to engage people in conversation or activity.
- Three people were funded for one-to-one support to enable them to take part in activities and go out in the community. This did not happen. One of these people said they never had staff working just with them and had no opportunities to do the things they liked to do, such as go out in the community. We saw another person spent time alone and without interaction. They presented as anxious at times and there were no available staff to offer reassurance. There was nothing in people's care records to show any one to one support was provided.

● We saw minutes from a residents and relatives meeting held in February 2019. It was stated the organisation had stopped paying staff when accompanying people out and if family wanted staff to escort their relative then family would have to pay the staff for their time.

The lack of assessing and planning care and support meant people's needs were not identified and met. This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Because of the level of the concerns we asked the provider to respond to us and they confirmed actions had and were being taken, in respect of the risks described above, to ensure people received person-centred care and that this was reflected in their care plans.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● People's care plans did not provide sufficient information about their communication needs. For example, one person's communication plan stated, "[Name of person] is unable to communicate most of his needs. Staff to anticipate when [person] is likely to require toilet, when he might be hungry or thirsty, when his personal hygiene needs attending to, when he will need pressure relief, repositioning and when he is likely to need stimulation through activities and social contact."
● Information was not available to people in an accessible format.

Improving care quality in response to complaints or concerns
● There was a complaints procedure in place.
● A complaints log showed complaints received up to December 2018 had been dealt with appropriately. A monthly summary of complaints had been completed which looked for themes, trends and lessons learnt. However, the manager could not locate the complaints log for 2019. Governance meeting records for February and June 2019 showed two complaints had been received. There were no records to show what the complaints were about or what action had been taken in response. We were unable to establish if any other complaints had been received in 2019.

Processes in place to deal with complaints were not effective. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Because of the level of the concerns we asked the provider to respond to us and they confirmed actions had and were being taken, in respect of the risks described above, to ensure complaints were responded to and recorded.

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 Good. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- The service was registered in May 2012 and has a history of breaching regulations and failing to sustain improvement. In September 2012 the service was inspected and there were no regulatory breaches. In August 2013 the service had four breaches of regulation relating to consent, safeguarding, medicines and records. In January 2014 there were no regulatory breaches. In December 2015 the service was rated Requires Improvement with regulatory breaches relating to dignity and respect and governance. In 2017, the service had improved, was rated Good and was no longer in breach of regulations; however, we found at this inspection, this improvement had not been sustained.
- The service was not well-led and management was weak and ineffective. The registered manager had left the service in May 2019. A temporary manager had been appointed and was present on both days of the inspection, as were senior managers.
- The managers failed to provide effective leadership, direction and support to the staff team. Communication about people's needs and risks and how to manage these was inconsistent and staff were left to fend for themselves.
- The lack of leadership had resulted in a poor culture where outcomes for people were not considered. People's needs were frequently overlooked and their basic human rights not respected.
- Quality management systems were ineffective at addressing issues raised and provider oversight of the service was poor. For example, medicine audits in June and July 2019 had identified issues which were still present on the day of the inspection, such as the unlocked medicines fridge and the 'do not disturb' tabard not being worn by the nurse.
- Systems and processes did not drive forward improvement.
- The provider told us they had taken action in response to issues we raised on the first day of inspection. However, when we checked some of these had not been completed. For example, ensuring there were sufficient staff to meet people's needs, making sure pressure relieving mattress were set correctly and people's dietary needs were met.

The lack of consistent and effective leadership and robust quality assurance meant people were at risk of receiving poor quality care. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Because of the level of the concerns we asked the provider to respond to us and they confirmed actions had

and were being taken, in respect of the risks described above. They confirmed new managers had been brought in and they were recruiting a permanent manager who would be registering with the CQC. They confirmed effective quality assurance systems would be put in place.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; 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; Working in partnership with others

- The registered manager had engaged with people and their relatives through regular meetings and we saw minutes from the last meeting in February 2019. However, there had been no meetings since the registered manager had left.
- Similarly, staff meetings had been held by the registered manager in February and April 2019 but none had taken place since then.
- The service worked in partnership with other agencies. Care records showed input from a range of professionals including GPs, community matrons, speech and language therapists and opticians.

Because of the level of the concerns we asked the provider to respond to us and they confirmed actions had and were being taken, in respect of the risks described above. They confirmed meetings would be held with people who use the service, relatives and staff to inform them of management changes and provide an opportunity for their feedback.