Ringdane Limited

Gosmore Nursing and Care Centre

Inspection report

Hitchin Road
Gosmore
Hitchin
Hertfordshire
SG4 7QH

Tel: 01462454925

Date of inspection visit:
04 June 2019
07 June 2019

Date of publication:
22 August 2019

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?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service:
Gosmore Nursing and Care Centre provides accommodation, personal and nursing care to older people. The care home accommodates up to 70 people in one purpose built building. At the time of the inspection 40 people were living there.

People's experience of using this service:
People had their individual risks assessed but did not always receive care that promoted their welfare. For example, pressure care management. As a result, people suffered harm. People were not always supported to safely. Some people had unexplained bruises or skin tears that had not been reported to the local authority safeguarding team or investigated to establish the cause.

People told us in most cases that they received their medicines when needed, however they were not always managed safely. Some people had missed doses of medicines which may have had an adverse effect on their health.

People did not receive care that met their individual needs and feedback from people about the service provided was poor. 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. Policies and systems in the service did not support this practice. Complaints and feedback received were not appropriately managed in the home to give the provider an accurate view of the issues being raised by people and their relatives.

People did not receive the appropriate support with eating and drinking. Some people had lost weight, and this was not being monitored or managed effectively by staff. Other people were placed at risk of not receiving enough to drink.

The provider had systems in place to help them identify and resolve any issues in the home. For example, audits and action plans, which included involvement from the provider's quality team. However, these were not used effectively. We found the concerns from the previous inspection remained a concern and further issues found at this inspection had not been identified by the providers quality monitoring.

The registered manager was not well known throughout the home and feedback about them was mixed. Staff were not clear about what was expected of them and any lessons learned from events or incidents had not been shared with staff, meaning there was missed opportunities to address shortfalls.

This was the fourth inspection when the service had failed to achieve a Good rating.
People were not always happy at the service. Feedback about the delivery of care varied. Privacy and dignity were not always promoted. People told us that they were not always able to choose how to spend their time or encouraged to make decisions about their care. People's care plans needed development and were

contradictory in places.

People gave mixed views about the activities available. People who were in their rooms were at risk of being isolated.

People, relatives and staff told us that there were not enough staff. On the day of inspection people did not have their needs met in a timely fashion. There were systems in place to help ensure staff were trained and received regular supervision, however, this was not always actioned, and staff felt they were not listened to. The recruitment process was not robust and placed people at risk of being supported by staff who were not suitable to work in a care setting.

The service met the characteristics for a rating of "Inadequate" in all key questions.

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

Rating at last inspection (and update):
The last rating for this service was requires improvement (15 June 2018) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to make improvements. At this inspection not enough improvement had been made and the provider was still in breach of regulations.

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

Enforcement:
We have identified breaches in relation to people's safety and welfare, safeguarding people from abuse, management of the service, working in accordance with the Mental Capacity Act, and the lack of person centred care and dignity promoted at this inspection.
For requirement actions of enforcement which we are able to publish at the time of the report being published:
Please see the action we have told the provider to take at the end of this report.
Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.
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.

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 work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning

information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe Details are in our Safe findings below.	**Inadequate**
Is the service effective? The service was not effective Details are in our Effective findings below.	**Inadequate**
Is the service caring? The service was not caring Details are in our Caring findings below.	**Inadequate**
Is the service responsive? The service was not responsive Details are in our Responsive findings below.	**Inadequate**
Is the service well-led? The service was not well-led Details are in our Well-Led findings below.	**Inadequate**

Gosmore Nursing and Care Centre

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 a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type:
Gosmore Nursing and Care Centre 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.

The service had a manager 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.

Notice of inspection:
The inspection was unannounced.

What we did before the inspection:
Our inspection was informed by evidence we already held about the service. We also checked for feedback we received from members of the public and local authorities.
We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and

improvements they plan to make. This information helps support our inspections.
During the inspection:
We spoke with the registered manager, the regional manager, and nine staff members. We spoke with 19 people who used the service and three relatives about their experience of the care provided. We reviewed eight people's care records, medicines administration records and other records about the management of the service.

After the inspection:
We asked the provider to provide us with information detailing how they would immediately mitigate risks to people. We reviewed information provided by them to test if the actions were effective.

Inadequate

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management
At the last inspection on 8 May 2018 we found that people's safety was not always promoted. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that no improvements had been made in relation to the concerns.
On the first day of inspection on 4 June 2019, we identified some immediate risks to people's safety. We asked the provider to tell us what action they would take to mitigate these risks and ensure people were safe. The provider sent us a detailed action plan showing the actions they were taking. We tested whether these actions had been taken on the second day of inspection on 7 June 2019 and found that they had.

●People had their individual risks assessed. However, care was not always delivered in accordance with these risks and management plans.
●People who were at risk of developing a pressure ulcer did not receive appropriate and safe care. We saw people were not repositioned in accordance with their plans and assessed needs, mattresses were set incorrectly, and dressings were not changed at required timescales.
● People were at risk in relation to fire as Oxygen management systems did not always promote safety. Risk assessments were not sufficiently detailed, staff and managers were unaware of the risks of using oil-based emollients and signage was not in use to advise of oxygen use.
● A fire risk assessment had been carried out in November 2017 and actions identified had been signed as completed. However, there was no record of an annual review being completed. The registered manager told us that this had been completed by the provider, but no evidence of this had been sent.
● Accidents and incidents were added to the provider's electronic system. This system collated the information and it included what action had been taken. This was not effectively reviewed by a member of the management team to enable them identify themes and trends to help them reduce the risk of recurrence.

Due to people's safety not consistently being promoted and placing people at risk, this was a continued breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● People who had bedrails in place had the protective bumpers on to help protect them from injury.
● People had their individual evacuation needs assessed. Staff were aware of how to evacuate people in case of a fire.

Systems and processes to safeguard people from the risk of abuse
●At the last inspection on 8 May 2018 we found that the appropriate action for unexplained injuries was not taken.

●At this inspection we found that no improvements had been made in relation to these concerns. This meant that people were remained at risk.
● People gave us mixed views about if they felt safe and why this was. One person said, "It's alright here mostly and they help you when they can but often there aren't many people (staff) around." Another person said, "I do mostly feel safe, but I spend a lot of time watching TV and there are no call bells in here (communal area) if you need them and can't walk. So today there is someone in here (new staff member on induction) but that's because you are here – normally there is no-one here. I don't think that's very safe." A third person said, "There are not enough staff. For example, last night the fire alarm went off. I was frightened. I expected lights to go on and for staff to come and tell us it was alright, but no one came, and no lights went on, it was very frightening. I was calling out for carers, but no carers came."
● Staff at the home had up to date training regarding safeguarding people from abuse and there was information displayed around the home. Staff knew how to report any concerns they had within the home and we saw that staff reported concerns they had to the management team. However, the management team did not always take the appropriate action following this being reported by staff.
●People were at risk of unsafe care because moving and handling procedures had caused injuries and no action had been taken in response to this. We saw, and people told us, that injuries had been caused when people had been supported by staff with their mobility. One person said, "I caught my hand on the hoist. They catch my toes on the hoist sometimes too. I hate that thing, I dread using it. I'd like to try myself with some help."
● There were several unexplained injuries and people with skin damage, which included pressure ulcers. The registered manager was unable to give us an accurate number of people this affected.
● Where a potentially unexplained bruise or skin tear was discovered on a person, these were not robustly investigated, and as such the provider could not satisfy themselves that the injury was not because of harm. Many injuries were linked to moving and handling techniques. For example, use of the hoist. The registered manager noted that staff needed to be reminding of how to work safely but there was no record of this. These incidents had not been reported by the home management through the safeguarding process.
● Following the inspection, we told the provider that they must report to us the number of people with skin tears, bruising and pressure damage or ulcers. They reported to us that they had carried out a full skin assessment on all people living at the home and the number of people was significantly higher than the number recorded on their internal recording system. This demonstrated to us that while the provider was now taking the appropriate action to protect people, there had been a negative impact on people.

However due to the concerns found in relation to unexplained injuries and the lack of proper investigations or reporting, this was a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staffing and recruitment
At the last inspection on 8 May 2018 we found that people we not always supported by enough staff and this was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.
At this inspection we found that no improvements had been made in relation to these concerns.
● People told us there were not enough staff to meet their needs. One person said, "I have rung my bell at night, no-one has answered, and it is still ringing the following morning." Another person said, ""I ring my bell and sometimes I can wait 2 or 3 hours. I worry because if I ring again they will get cross." Relatives also told us there were not enough staff. One relative said, "There are not enough staff, I come every day and there are not enough staff you just have to listen to the bells going constantly. There are loads of agency staff and so people have to put up with lots and lots of different people all the time."
● Staff said there were not enough staff. They told us this meant people had to wait for support. Staff told us some shifts were not able to be covered and they worked with fewer staff than usual.

● Throughout the inspection we saw people did not always receive support when they requested it. Staff were busy, and people told us they regularly had to wait to use the toilet. One person told us that they were woken at 6.30am for staff to change their pad. They then had to wait until they received personal care to use the toilet. On the day of inspection, the person waited until 10. 45am.The person was noted on their care plan as being continent but wore a pad for security. However, they told us that they needed to use the pad due to the delay in care.

●People told us that call bells rang for long periods day and night. We noted that call bells rang for long periods of time. We asked if the call bells were monitored or checked for response times. We were told by the registered manager and regional manager that they were not monitored.

●Some people did not have their call bells accessible or plugged in. This increased the risk of people not being able to call for assistance when they needed it. In one room the call bell was inaccessible, and the person told us, "I don't like being shut in, I tell the staff not to shut the door, but they do, and I really don't like it." We went back twice in the morning having left the door open and both times it was shut again. Another person told us, "The call bell just stops working sometimes, I tell them, but they don't seem that bothered about it."

● The registered manager was working with the provider to manage recruitment and address staff vacancies. They used agency staff when needed to cover any shifts. Agency staff had a folder which listed people's main needs. The registered manager did not know where this was and needed to ask the clinical manager to show it to us. This meant that they were not checking that the care listed for people for agency staff information was accurate.

● Recruitment files included information to help the registered manager make good decisions about the staff they employed. However, gaps in employment history had not been explored in all cases. This increased the risk of unsuitable staff working with people due to a lack of robust recruitment checks.

Therefore as people were not supported by staff in a way that met their needs in a timely manner this was a continued breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● The home was not clean on the day of the inspection. Carpets were stained, and cob webs were seen in bedroom corners. The home smelt of urine throughout the day of the inspection and where areas were cleaned these smelled fresh for only a short time until floors dried and the odours returned. This was also a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● Staff had received training and were seen to use gloves and aprons. However, we noted that at times staff used gloves when assisting people and they were not completing a task which was a hygiene risk which did not promote people's dignity.

Using medicines safely

● People's medicines were not administered, stored and recorded safely. We counted a random sample of medicines. Of the 10 boxes we counted, five had discrepancies in their quantities that indicated incorrect doses and poor record keeping.

● Regular checks and audits were completed. However, the daily checks and counts of medicines had not identified the discrepancies in quantities. This increased the risk of people not receiving their medicines as prescribed and needed.

●People did not always receive medicines when they needed them. One person was complaining of pain and was not prescribed any pain relief, another person had an ongoing urinary issue and the prescribed medicine had not been given for two days as staff could not find the box that was in stock. We also noted one person was complaining of pain and when we asked the nurse they told us the medicines were timed and it was too soon to give another dose. However, no consideration was given to getting the GP to review

the person for alternative and more effective pain relief.

People did not always receive their medicines in accordance with the prescriber's instructions and this was also a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

- Staff told us that they were just given instructions from the management on what they needed to do without having a discussion or opportunity to feedback on any issues.
- We reviewed some staff meeting notes and found that they had not identified any concerns we found during this inspection which demonstrated the management team had not identified the shortfalls we found as a concern.
- There was a lack of guidance in the home and not all issues that had arisen were documented, including any action taken to improve and therefore not shared as an opportunity for learning.

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

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

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

● People gave mixed views about the food. One person said, "The food is lovely I like it all." Another person told us, "I don't like the food, it tastes like cardboard. They make West Indian food too and there's not much choice and I don't like that food, I'm a plain food person." Relatives told us that the food was repetitive and for people with a soft or pureed diet it was not very imaginative.

●Food choices were taken earlier in the day and staff did not check with people who may have short term memory loss or remind them what they had chosen when delivering the meal to the table.

● People were not always given support in a kind and patient way if they needed help to eat. Some staff chatted with people while they supported them, others did not. Staff did not always recognise the need for support. One person said, "I really wish I remembered to ask them to cut up my food when they bring it, I often forget and they don't seem to have any idea how difficult it is to be at this angle and try and cut up things, or how hard it is to balance cornflakes and milk and get it to your mouth without spilling it."

● One person was given a jacket potato with butter as they couldn't eat meat. No alternative to meat was given. The staff member left the person with their food, the person told us that they were unable to eat unaided all the time so didn't eat as it was hard work. The person said to the staff member that they didn't want it. The staff member was about to walk away and said to us, "[Person] doesn't eat much." We asked the person if there was a reason why they didn't eat very much, and they told us, "I can't really manage a knife and fork, it's all so difficult." The person was vegetarian hence they did not wish to eat the cottage pie which was the menu alternative. This was their main meal of the day and they told us, "It's a plain potato like this very often." The person was given no plate guard or adapted cutlery to support them to eat independently, despite only having the use of one hand.

● Allergies, dietary needs and weight changes were shared with the kitchen staff on a notice board. The folder which included information about people's needs contained inaccurate information. The staff member responsible for providing the evening meal told us that food was not fortified and other dietary needs, such as for those with diabetes, were not catered for.

●The management team told us that this was not the case and dietary needs were catered for and food was fortified. However, we noted that people who needed a modified consistency were given soup for their evening meal. Even though they were assessed as being at high risk for malnutrition, nothing more substantial was prepared.

●Some people were noted to be losing more than 10 percent of their body weight. The management team could not confirm that fortified foods were given consistently as they had not checked it was happening.

●People told us that there were no hot drinks available when people wake up, even if they asked, they have to wait until breakfast at 9/9.30am. One person said, "I was awake before 8am and I asked for a cup of tea,

but they told me I could have it with breakfast, I didn't want it with breakfast I was parched but they made me wait until 9am." In one room there was a note left with the time the drink was refreshed. The time on the note was 18.05 the previous day. Another person had two thickened drinks left on their table untouched. They could not reach them and needed assistance, however this assistance had not been given.

●Staff recorded people's food and drink intake where people were assessed as being at risk of not eating or drinking enough. However, there were no fluid targets, fluid consumed was not tallied each day to ensure people had received enough to promote their well-being.

Due to people not receiving appropriate support for nutrition and hydration, this was a breach of Regulation 14 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Supporting people to live healthier lives, access healthcare services and support

● People were not always promptly supported by the nurses in the home. A person was worried about their relative who lived in the home and requested they have their blood pressure taken. They had waited over an hour – and finally we asked a staff to find the nurse to make the request again.

● A person told us, "I've had all the symptoms of [health condition]. I've been in pain for weeks on and off. The doctor refused me antibiotics and told me to drink more but then my pad gets soaked and it doesn't help I'm still in pain." The person had missed two doses of the medicine which had been prescribed, to treat frequent urination, as staff had not got the box from the stock cupboard. Staff had also not followed up with the GP to advise that the person was still experiencing painful symptoms. This increased the risk of ill health to the person.

●Another person told us, "I've got cataracts and can't see properly anymore. No-one is checking on it. I'd love a visiting optician to come out."

● We saw that all changes in health were documented but staff were not always aware of these or following the instructions. For example, changes to dressings and pressure care management. On 4th June one person who had a dressing on their hand had not had it dressed or checked since 30th May. On the 7th June they told us, "They changed it and they were shocked at how green and smelly it was."

Due to people not always getting their healthcare needs met promptly, this was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

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 to see if people were supported to have maximum choice and control of their lives and if staff supported them in the least restrictive way possible and in their best interests. We also checked if the policies and systems in the service supported this practice.

● People were not supported consistently in accordance with the principles of the MCA. People had their capacity assessed in relation to important decisions about their care and in some cases best interest decisions were recorded. However, best interest decisions recorded for people were not decision specific but generalised. It was not always clearly recorded if the person did or did not have mental capacity.

●The quality of the assessments varied, for one person we were not assured that the person had understood

the questions, but the staff member had stated they had capacity. As a result, the person was not receiving care that was in their best interests. As a result, they may have been missing out on important health and personal care support.
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 consistently support this practice. This was a breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014

●DoLS applications were made but there were no authorised applications recorded at the time of inspection.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People, and their relatives where appropriate, were not always involved in planning care.
● People's choices were not always reflected in the care plans and staff did not always give people choices throughout the day. For example, what time to get up and food offered at mealtimes. Care was delivered in a task orientated way. One person said, "It seems to me they give old people anything and they think that it doesn't matter, like the food, they know we can't do anything about it, so they give us what they like."

Adapting service, design, decoration to meet people's needs
●Some bedrooms were personalised, others were quite plain. Corridors were bland and although there was signage for some rooms, such as bathrooms, bedroom doors were not personalised. Some had name plaques, others were missing. There were no memory boxes or interesting items to stimulate or support people with dementia or sensory impairment to be able to orientate themselves throughout the service. This was an area that required improvement.
●Carpets in some corridors were stained and odorous. The regional manager told us there were plans to change these. One person was hoarding in their room and this was creating an infection control and fire risk to the rest of the home. The person had been seen by the mental health team and was now discharged. However, no steps had been taken by the management team to address this issue via risk assessments and support plans. This was an area that required improvement.
● The service was a listed building which had been converted into a care home. There was ample communal space which was decorated nicely, and we saw people using this.
● There was a pleasant garden area which people used.

Staff support: induction, training, skills and experience
●Staff told us they were happy with the training they received. One staff member said, "Training is with a trainer now which is very good and not just e-learning." We saw that some training was due to be updated. For example, moving and handling theory training was only at 76% and there was no record of practical training using equipment for this subject. This was an area that required improvement.
●Staff told us they received an induction training when they started, and this included training considered mandatory by the provider. This included, fire safety, infection control, safeguarding and manual handling. They told us they then worked together with a senior member of staff to learn about the routine in the home. A staff member said, "New staff will be shadowing for two days and then they will work together with the mentor so that they could be observed how they work." They told us the mentoring period was as long as staff needed and could be signed off as competent to work alone.
●Staff told us they had supervisions and staff meetings, however not all of the staff we spoke with felt supported. One staff member said, "Management don't listen to staff. If we have staff meetings it is all about what the manager expects not what staff thinks or needs. They never listen if we report anything and we get no feedback."

Staff working with other agencies to provide consistent, effective, timely care

- The home was being visited by the clinical commissioning group to improve care for people. However, this had not been fully embraced by the management team to make a difference to people.

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

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

● People were not always treated respect and kindness. Staff observed spoke with people kindly, however we received mixed feedback from people and relatives.

One person said, "The girls are very nice, but they don't stay long, well some of them." Another person said, "[Staff member] is in a good mood today, [they're] nice when [they're] like that but it's not always the case." A third person said, "The carers are very good mostly, not the agency people but the ones we see every day they do care but they are very, very busy all the time." Feedback from relatives was that staff often only gave basic care and were not attentive.

● Staff were not attentive to all of people's needs. For example, hearing aids were not cleaned or checked to ensure they were working, glasses were not cleaned. One person said, "I have hearing aids, but I haven't had them checked for years, they are just in a drawer now, it's difficult because people have to shout." Another person said, "I have hearing aids, but they don't work anymore, they don't fit properly, and I don't know how to get it sorted."

●Consideration was not given to what impact staff actions may have on people. For example, we noted housekeepers would vacuum outside the rooms of people who were in bed on end of life care. This meant that the end of life atmosphere for the person that was supposed to be calm and dignified suddenly it was loud, and the noise activated door closers meant the doors slammed. One person told us, "Every door in this place slams, night and day, it makes you jump."

● Some people's life histories, religion or cultural beliefs, hobbies and interests were recorded in people's care plans. However, this was not used to influence staff approach and improved people's lives.

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

● Care plans did not evidence that people were involved in their care. Limited information was available for what people`s likes and dislikes were. People were not given a choice of what time they liked to go to bed or get up in the morning.

● We did not hear staff asking or promoting people's choices throughout the inspection.

● People and their relatives told us that they did not feel involved in planning their care and it was not always delivered how they wanted it to be. One person said, "We do what we are asked to do. I can do some things like not go to the Church service or watch TV if I want to but generally they tell us what to do like going to bed." Another person told us, "No-one speaks to me about what I need, they just get on with what they do." A relative said, "We've been here 6 months, and no-one has ever spoken to us about the care [person] needs or the help they can give them, no one."

Respecting and promoting people's privacy, dignity and independence

● Staff failed to protect people`s dignity. For example, a person`s bedroom door was open, and we saw them lying in bed. They were dressed however their trousers were pushed down exposing their private areas clearly visible from the corridor. We rang their call bell for staff`s assistance. A staff member came to check on the person who asked where their cap was. The staff member looked in the room and went out to ask another member of staff if they can find the cap. Another member of staff came and checked until they found this. No attempt was made by either member of staff to help the person into a more dignifying position, pull trousers up or even close the door although people could look in form the corridor. When questioned staff said they could not do anything because the person was always pushing their trousers down and holding their private parts. No consideration had been made about how to promote the person's privacy. The person had been left in the same undignified position and with the door open from 9am to 11am.
● Throughout the day we observed bedroom doors open especially for people who were not able to communicate or were spending their days in bed. Their preference was not recorded in care plans if they wanted their door open and their dignity was not considered where they were visible in bed by any visitors in the home.
● People were not given a choice regarding having a male or female staff member providing their personal care. One person said, "I have a couple of men who look after me. I've never been asked, and I've had to accept it if I want a service that's what I have to have." Another person said, "No-one has ever asked me about male or female carers. The first time a man walked in and I had nothing on I didn't like it, but he was very professional, and I've just got used to it." This was not reflected in care plans and the management team were not aware of this.
● Care plans were stored in a secure office.

People were not being treated respectfully and dignity not being promoted, this was a breach of Regulation 10 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

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

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

●People did not receive personalised care and support. Care plans were not developed to offer staff guidance and information on what people liked, disliked or preferred. One person who liked showers told us, "No showers, I like showers but here I don't think they have the equipment." A relative told us, "[Person] has been here 6 months and they've never asked her about a shower." However, there were options of showers which just had not been offered to others as another person told us, "I have a shower once a week and a wash every day, that's just what they do." However, the choice and frequency of showers was not available.

●Care plans were generalised and despite people having nursing needs which meant that they had some health conditions which affected their day to day lives, health care plans were not in place. For example, where people lived with Chronic Obstructive Pulmonary Disease (COPD) there was no care plan for staff to understand how this impacted on their day to day life. Staff had no guidance to know how to maximise people`s health. A person had a diabetic care plan in place, however this was generalised for signs and symptoms of complications.

●Staff were seen providing care in a task led way and not seeing the person behind their `must do' actions. For example, in the morning staff were allocated to work on a certain area of the home. They offered personal care from room to room instead of asking people for their preferred time to get up. One person said, "They do ask us if we want to go to bed but as soon as supper is over they just want to get on, so we go to bed at 6 or 6.15." Another person told us, "They don't get me up til nearly lunchtime most days, I'm just shut in here, I'd like to get up a bit earlier really and go out there where it is more convivial."

●Some staff members were managing to support people with behaviours that challenged when receiving personal care. However, their approach and techniques used were not captured or shared with other staff members to ensure people received their care as they preferred, and they did not display any challenging behaviours.

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

● People told us that there weren't many activities provided to promote and maintain their well-being. One person said, "You see those pictures (activity board in the hall), they are really old, but they like you to think that's what happens."

●People in their rooms had little stimulation. One person said, "Sometimes it would be nice to have a chat just to break up the day." A relative told us, "There's not much going on, it doesn't impact much on [their relative] but there isn't much for others."

● The activities person told us that there were activities planned for 04 July, a BBQ and that they had theme days some months with different sorts of food and activities. They said that they mix up general events with one to ones for people in their rooms. One person told us she had had her nails done and she was

delighted. They said, "The lady spent time with me and she wanted them to look nice, they were lovely." However, we noted that their nails were very chipped which indicated this was overdue to be re painted or have the varnish removed.

● On the day if inspection we saw there were communal activities available in the activities room and the conservatory.

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.

● There were no aids available to support people with communication when they were unable to verbalise choices. Staff did not show visual prompts to people.

End of life care and support

● The service offered end of life care. When people were nearing the end of their lives, care plans were put into place for supporting people. However, end of life care plans were basic and only explored people's wishes in terms of their preferred place of death and if they wanted to be resuscitated or not.

●We saw people living in the home who were assessed as being on end of life care. The care they received was unsatisfactory and people did not always receive the care they needed regarding pain relief, skin care, choice, dignity and nutrition.

● Feedback from relatives about the care loved ones had received at the end of their lives was mixed. One relative told us it was extremely poor.

●The regional manager told us that this was an area they were working in developing.

Due to care not being delivered in a person-centred way, shortfalls in care plans and end of life care and a need to further develop activities so that they meet everyone's needs, this was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

● The provider could not give us assurance that all complaints and concerns had been captured and therefore responded to appropriately. We had received feedback which told us that complaints had been raised. These were not listed on the monitoring tool. Our observations of care on the day found concerns similar to those raised in complaints. The registered manager told us that they did not record things that were raised and actioned straight away. This meant they could not have oversight of themes and trends of issues in the home.

● People raised concerns with us during the inspection. However, none of these concerns were reflected in feedback collated by the service. Relatives also told us they had made complaints. One relative said, "I have made a formal complaint about the bell system. It rings, it's high pitched and it goes night and day, there is no peace from it at all and all they said was we could move rooms. That's not the point, it's all over the home and the final straw was one day when it went solidly for 1.5 hours." Another relative said, "One time recently [person] didn't have a bed sheet on the bed, when I complained they told me they were short of bed sheets. I find that a bit unusual, it's fairly basic."

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

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.

At the last inspection on 8 May 2018 we found that the systems in place to monitor the quality of the service and address the shortfalls were not effective. The provider sent us an action plan stating how they would meet the standards and address areas that required improvements.
At this inspection we found that no improvements had been made in relation to the concerns found at the last inspection and further concerns were identified.
Following our first day of inspection on 4 June 2019, we asked the provider to tell us what action would they take immediately to mitigate the risks and ensure people were safe in the home. The provider sent us a detailed action plan showing how they would ensure everyone was safe. We tested whether these actions had been taken on the second day of inspection on 7 June 2019 and found that they had been. This reduced the immediate risks to people but was only prompted by the inspection not the providers quality monitoring.

Provider plans and promotes person-centred, high-quality care and support, and understands and acts on duty of candour responsibility when things go wrong

- People told us that the registered manager was rarely around the home and not many knew who they were. However, one person said, "Yes I know the manager, he's not here often but when he is I can talk to him." Relatives also told us that they did not find the registered manager visible or approachable. One relative said, "I know who he is, he strikes me as a bit secretive and he's not here very often."
- We were told by people, relatives and staff that the registered manager was not visible in the home and were not available if anyone needed to speak with them. Most people told us that they would speak to a relative or friend or a staff member and not the registered manager because they didn't know who it was.
- There were daily handovers records detailing people's needs to give the staff an overview. The management team did not monitor this to ensure people received the care that they needed.

Managers and staff are clear about their roles, and understand quality performance, risks and regulatory requirements

- The registered manager did not use the internal governance systems to help them identify issues in the home.
- The registered manager had not identified any areas of the home as an area needing further development. resolve issues in the home.
- The regional quality team visited the home weekly to check on the progress of issues they had identified and the progress of the action plan submitted to the CQC after the last inspection. An action plan was developed detailing how they would resolve the shortfalls.
- This action plan had not identified all of the concerns we had found on inspection, nor had it identified the

discrepancies in the findings in the home and the feedback they were receiving through the survey system. ● There had been no challenge to the lack of complaints recorded, even though there were failings in the home.
●The provider had issued the registered manager with a letter in May 2019 stating that the home was now a focus home and the improvements needed to be made in a shorter timeframe. However, there was a lack of action taken swiftly enough to bring about the required changes.

Working in partnership with others
● The registered manager had not ensured that other agencies were informed of any issues arising. Where people had unexplained injuries or develop pressure ulcers, this was not reported to the local authority nor was it reported to the CQC. Where complaints had been received, these were also not shared.
● The registered manager had not developed relationships with visiting professionals.
● We shared our concerns with the local authority and clinical commissioning group (CCG). These agencies fund the care for some people living at the service. The CCG had been visiting the service as they had concerns about the nursing care being delivered. However, the management team had not ensured they effectively used this support to make sure people received the correct care.

Engaging and involving people using the service, the public and staff
● People and their relatives had meetings to discuss the service. One person said, "We have meetings, someone usually comes like the chef or a nurse or someone in the home and we can ask questions and they tell us things too, they are quite good." A relative told us, "We used to have relatives' meetings but that hasn't happened for a long time. We don't have feedback forms or surveys, there are some forms at the front door and we can fill those in."
●We noted that the registered manager did not always these meetings. The meetings looked at activities and menus and gave some information about the home. However, the notes were not always typed up, so the content seen was basic and difficult to read. There were no action plans as a result of the meetings.
● The service had an electronic tablet in reception that was used to gather feedback from people, relatives, staff and visitors to the home. All feedback reviewed from this was positive, however this did not reflect the feedback we received as part of the inspection process.
● A member of the provider's management team told us that they had flagged that the home had very positive feedback, but they were aware of some issues in the home. However, this had not been addressed prior to the inspection.

Continuous learning and improving care
● The clinical lead had offered staff the opportunity to become champions for key areas within the home. For example, falls, infection control, end of life care, medication and nutrition. Notes from a staff meeting showed that all staff had declined the opportunity for the further training and responsibility.
● The service had a history of failings to meet the standards. The provider carried out regular quality checks. The learning from the home's history and ongoing performance issues had not been shared with the home's staff for any required actions to be taken.
●Following our first day of inspection on 4 June 2019, staff were given the information of concern and what action was required immediately to ensure people were safe in the home. We tested that this information had been shared on the second day of inspection on 7 June 2019 by speaking with staff and carrying out observations.

Due to the concerns found on this inspection, and the continued failings in the home, this is a continued breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive person centred care that took account of their needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The principles of the Mental Capacity Act 2005 were not consistently adhered to.

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems in place did not ensure that people were protected from the risk of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People's were nutritional and hydration needs were not always supported.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing People did not have their needs met in a timely manner and staff recruitment was not robust.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The governance systems had consistently failed to identify issues in the home and take necessary action to make improvements.

The enforcement action we took:

We imposed a condition on the provider's registration to ensure improvements were made to their governance systems.