Mr Anthony Howell

St Bridget's Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
St Bridget's Residential Home is a residential care home providing personal care for up to ten people aged 65 and over. At the time of our inspection there were nine people using the service. Accommodation is provided over two floors of a converted house situated in a residential street.

People's experience of using this service and what we found
People told us they felt safe and were happy. Relatives told us the staff were kind and caring. However, we found shortfalls that had placed people at risk of harm.

The service had not made many improvements since our last inspection where we found breaches of the regulations in relation to reporting incidents and risk to statutory agencies, making notifications to the care quality commission, record keeping of peoples' care needs and governance. This had led to us finding ineffective systems and processes that had placed people at risk of harm.

The service had not appropriately identified risks to peoples' health and safety and medicines were not managed safely. There were not sufficient staff to ensure peoples' needs were met in the afternoons.

People had not had their needs robustly assessed before they were admitted into the building to ensure the service could meet their care needs. The adaptation and design of the building did not support people with disabilities and reasonable adjustments had not been made to ensure people could enter and exit easily.

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

Care plans were not person centred and staff had not been provided with enough information to meet people's individual care needs. This was identified at our previous inspection and no improvements had been made.

People had not been supported to take part in activities whether in a group or one to one that were socially or culturally relevant to them. This had been identified at our previous inspection and no improvements had been made.

There were no robust governance systems and processes in place to monitor and assess the quality of the service. This had led to shortfalls found in the inspection that had placed people at risk of harm. A lack of governance and oversight had been identified at our last inspection however no improvements had been made at the service.

People and relatives spoke positively about the staff and told us they were "kind and caring." People said if

they asked for something, for example a cup of tea, they didn't have to ask twice.
Staff knew how to report signs of abuse and the registered manager had made appropriate safeguarding referrals; this had improved since our last inspection. We received positive feedback from one healthcare professional who told us staff listened to their instructions. People enjoyed the food.

People and relatives told us they found the registered manager approachable.

For more information, please read the detailed findings section of this report. If you are reading this as a separate summary, the full report can be found on the Care Quality Commission (CQC) website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 18 August 2021).
At our last inspection we found breaches of the regulations in relation to reporting incidents and risk to statutory agencies, making notifications to the care quality commission, record keeping of people's care needs and governance. The provider completed an action plan after the last inspection to tell us what they would do and by when to improve. At this inspection, we found the provider remained in breach of regulations.

Why we inspected
We were prompted to carry out this inspection due to concerns we received about record keeping of people's care needs, medicine management, social engagement and governance. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have found breaches in relation to keeping records to provide consistent and safe person-centred care, identifying and managing risks, providing support to people in a restrictive way, governance and having sufficient staff to meet people's care needs.

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.

Follow up
The overall rating for this service is inadequate and the service is therefore in special measures. This means we will keep the service under review and will re-inspect within six months of the date we published this report to check for significant improvements.

If the registered provider has not made enough improvement within this timeframe and there is still a rating

of inadequate for any key question, we will take action in line with our enforcement procedures. This usually means that if we have not already done so, we will start processes that will prevent the provider from continuing to operate the service.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

St Bridget's Residential Home

Detailed findings

Background to this inspection

Inspection team
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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors.

Service and service type
St Bridget's Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and we looked at both during this inspection.
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was a registered manager in post.

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. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
Inspection activity started on 7 July 2022 and ended on 27 July 2022. We visited St Bridget's Residential Home on 7, 8 and 21 July 2022. We spoke with six people who used the service and four relatives about their experience of the care provided. We spoke with nine members of staff including the provider, registered manager, senior care workers, care workers and the chef. We observed care to help us understand the experience of people who could not talk with us. We reviewed a range of records. This included six people's care records and multiple medication records. We looked at two staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection we have rated this key question inadequate. This meant people were not safe and were at risk of avoidable harm.

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

- Peoples risks were not always assessed and when they had been, risk assessments were not always correct and did not always contain information to direct staff on how to mitigate risks to people. This placed people at risk of harm.
- The service had not completed risk assessments to identify people's risks to oral health, infection prevention and control and nutrition. People had not been assessed to determine if they were at risk of losing weight or malnutrition. This meant risks to people's health and wellbeing had not been identified and safety measures had not been put in place to reduce the risk of harm.
- Risk assessments were not always effective at reducing risks. For example, where people had been assessed as high risk of skin breakdown there was no further information instructing staff how to reduce the risks and this had placed people at risk of harm.
- We observed one person being assisted to use the standing hoist. The person looked unsafe and the sling too large. Staff we spoke with said they knew what equipment to use because of the care plan and the training they had and told us what sling loops they used. We checked the care plan and found no clear instructions for staff. We observed the same person being assisted later in the day and found other staff were using different loops on the sling meaning the person was not secure and at risk of falling through the sling. We discussed this with the registered manager who arranged for an occupational therapist to assess the person and ensure correct information was in the care plan for staff to follow.
- We received reports from the local authority that people had not had call bell leads in their rooms. This meant people had not been able to call for assistance if required. We found one person did not have access to their call bell. Staff said the person would not understand how to use the call bell. However, there was no risk assessment or actions recorded to ensure the person was checked regularly and the persons' daily notes did not show the person was checked on by staff at regular intervals.
- A member of the public was living in private accommodation on the second floor of the home. To access the accommodation the person had to walk through the main building and past people's bedrooms. We asked for a risk assessment to be completed to identify any risks to people using the service to keep them safe. The registered manager failed to complete this before the end of the inspection placing people at risk of harm. We informed the local safeguarding team.
- We visually identified two people with unexplained bruising. Staff had not identified the bruises during personal care. We brought this to the attention of the registered manager and a member of staff was asked to document the bruising on a body map. Staff were not asked to complete an accident and incident form. This meant the route cause had not been explored to enable steps to be taken to reduce a future occurrence and the registered manager was not able to monitor for themes and trends and learn lessons when things go wrong.

We found no evidence that people had come to harm, however the provider had failed to assess, monitor and mitigate risks to the health and safety of all the people using the service. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● Staff did not manage people's medicines safely. Medicines were stored in a trolley not affixed to the wall in a place where anyone entering the property through the back door had access to them.

● The medicine trolley was left unattended with medicine keys in the lock and medicine administration records (MAR) were left on top of the medicine trolley for any person to access.

● Open dates had not always been recorded on medicines. We found one bottle of a strong painkiller with no open date. On checking, staff found it had been opened in March 2022 and had now passed the expiry date. This meant the medicine was being administered after the efficacy had deteriorated putting people at risk of experiencing pain.

● Medicines had not been returned safely to the pharmacy. Medicines to be returned had been placed into a container and not signed out. This meant the service did not keep a contemporaneous record of the medicine meaning any person could take the medicines away to be used in a manner it was not prescribed for.

● MAR had not been completed correctly. Medicines had not been signed in by two trained members of staff. This meant the records could not be verified as accurate.

● As required medicines did not have instructions for staff to tell them the reason why the medicine should be administered, how much to give, what the medicine was expected to do and the minimum time between doses. This meant people were at risk of not having medicines as prescribed.

● Transdermal medicines monitored with extra controls due to the strength of the medicine had not been administered according to best practice guidance. Staff did not record where the patch had been applied to reduce the risk of the same site being used or the old patch not being removed. This had placed the person at risk of medicine overdose.

● One person was self-administering their inhaler. This had not been risk assessed or regularly reviewed to ensure the person was able to effectively administer the medicine as prescribed.

● Medicines had no oversight and governance as medicine audits had not been completed since July 2021. This meant people had been placed at risk of harm from not receiving medicines as prescribed.

We found no evidence that people had come to harm, however medicines were not always managed safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the inspection the registered manager told us St Bridget's Residential Home was working with the suppling pharmacy and now had an electronic system in place to manage medicines.

Staffing and recruitment

● There were not enough staff to meet people's needs. In the afternoon the service only had two members of staff on shift for eight people who required assistance from two members of staff due to their mobility needs. This meant people were left for long periods of time unsupervised or supported and there were no staff available in the building if those two staff were supporting someone. One relative said, "[Person] is worried if she was taken out of her room that she would be forgotten about as there does not seem to be much staff in the afternoon."

● The medicine round was completed whilst people ate their meals. This was task focused and a missed opportunity for staff to engage with people to enhance their mealtime experience. For example, one person was sitting at the dining room table on their own. We observed nice interactions from staff as they passed by but staff delivering meals to people in their rooms did not have time to sit with the person to chat with as

they ate. We spoke with the person who told us, "yes I enjoy speaking with people but there are not many people to speak too here."

● There was not enough staff to answer the door. On these occasions the registered or deputy manager would sit in the dining room to answer phone calls and open the door to visitors. The registered manager told us visitors were asked to not come in on days they could not do this. This meant people were at risk of isolation because visiting was restricted due to a lack of staff available.
● We discussed this with the registered manager who told us they allocated staff using a one staff to six people ratios. The registered manager did not know why this was and said, "It's just something I have always known." The provider and registered manager did not use a dependency tool. This meant people's dependency needs had not been assessed to ensure there were enough staff were on duty to meet their care needs.

We found no evidence that people had come to harm, however there was not sufficient numbers of staff to make sure people's care and treatment needs were always met. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had been recruited safely into the home. Recruitment procedures were in place to ensure that the right staff were recruited to support people.
● Appropriate Disclosure and Barring Service (DBS) checks and other recruitment checks were carried out as standard. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk from abuse

At our last inspection we found the provider had failed to share reportable incidents with external agencies including the local authority safeguarding team. 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. At this inspection, we found the provider had made improvements to reporting incidents.

● Improvements had been made since our last inspection and the local authority had been notified when reportable incidents had occurred.
● Staff had completed training and understood signs and symptoms of abuse. Staff knew who to report concerns to including the local authority safeguarding team. One staff member said, "I would report this first to a senior carer, if necessary, to the home manager and/or if necessary, to the responsible authority at Social Services."
● People told us they felt safe with the staff providing them care. One relative said, "I feel they are safe; Carers are fantastic. There are always two people to help [person] it may take 15 to 20 minutes but they always come."

Preventing and controlling infection including the cleanliness of premises
● We were not assured that the provider was admitting people safely to the service. The service had not assessed how people may be at risk from infections including COVID-19 and people's COVID-19 status had not been sought. This meant actions to reduce the risk of harm to people had not been identified and staff had not been instructed on how to meet people's needs. We discussed pre assessments with the registered manager and signposted where to seek further information to keep people safe.
● We were somewhat assured that the provider was using personal protective equipment (PPE) effectively and safely. We observed two members of staff not wearing masks on our first day of the inspection. We

discussed this with the registered manager and observed staff wearing PPE appropriately for the other days of inspection. We received feedback from people and relatives who told us staff did wear PPE. One relative said, "They definitely have their masks on."

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.

Requires Improvement

Is the service effective?

Our findings

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

At our last inspection we rated this key question good. At this inspection we have rated this key question requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA 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. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- The service had not always worked to the principles of the MCA. The service had not always reviewed people's mental capacity to make particular decisions and had not regularly reviewed people's capacity to consent to care.
- For example, one person was continuing to have drinks they had been medically advised to stop having. The person had a diagnosis of a mental impairment and the service had not assessed and reviewed their capacity to understand the risks they were taking and support them in their decision making.
- In another person's care plan the care home had recorded "has varied capacity" yet did not contain any further instructions for how staff should ensure the person understood the decisions they were making. No mental capacity assessments had been completed to assess or review capacity.
- Staff told us they sought consent before they provided personal care.

Whilst we found no evidence of harm, the care home had not ensured care and treatment was only provided with the consent of the relevant person. The requirements of the MCA had not been followed. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People cared for in bed and not known to be at risk of falls had bed rails in place as a form of restraint preventing them from getting up. One person told us, "I do not like the bed rails, they know how I feel about

it, they say they are a legality. I think I could get out of bed if they let me."
● Consent had not been sought and MCA had not been completed to assess capacity from people who had bed rails in place.

People had been placed under unnecessary restraint. This had impacted on their ability to choose how they wanted to live their lives. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● DoLs authorisations had been requested appropriately. There were no conditions placed on authorised DoLs at the time of our inspection.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Adapting service, design, decoration to meet people's needs
● People did not always have their needs assessed before they were admitted into the service. This meant the service had not ensured they had enough staff and the right equipment in place to ensure people's needs were met.
● The registered manager told us staff would be unable to bring one person downstairs easily as they spent their time in the room. We asked the person if they had been outside since they had lived at the service they said, "No." We asked if they would want to, they said, "Yes!" We discussed this with the registered manager who said, they would find it difficult because the size of the lift meant they could not easily bring the person downstairs in wheelchairs. This meant the person was confined to their room. This had not been discussed prior to admission.

We found reasonable adjustments had not been made to ensure people were able to easily enter and exit premises easily and this had impacted on people being able to access the garden. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● People told us they enjoyed the food. Comments from people included, "I enjoy my meals", "the food here is really good" and, "I enjoy what I am given."
● Kitchen staff told us they were aware of people's special diets and safe swallow plans because they spoke with people when they first come in and care staff updated them with any changes. One kitchen staff member said, "I feel involved I always check on what has been eaten so I know what people like and dislike."
● We observed people being offered a range of snacks and drinks and when people had not enjoyed their meal, we saw staff feed back to the cook. One relative said, "the kitchen staff make chicken sausages for [person] as they don't eat pork it's the little things like that that are so important."
● People told us they had enough to eat and drink. Records did not always reflect this. Fluid charts had been completed for all people using the service. Some days people were recorded as only having 600mls of fluid. Staff had not reported this to the registered manager or recorded any actions taken. We discussed this with the registered manager who said they were not aware of this.
● People we spoke with told us they not did always get a choice. One person said, "I only get one choice I can't ask for anything else" and another person said, "I don't get a choice, but I enjoy what I am given." We discussed this with the registered manager who said, "if people tell us they don't like something we will offer them something else."

Staff support, training, skills and experience
● Staff had the right competence, knowledge and training to carry out their roles. All staff had completed training including moving and handling, health and safety and tissue viability.

● Staff received an induction aligned to the Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.
● Staff told us they found the training provided them with the knowledge they needed to do fulfil their duties. One staff member said, "The training makes sense and is done regularly."
● Staff said they felt appreciated and supported to do their jobs. One staff member said, "I feel appreciated and am provided regular staff appraisals."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● The service worked with other agencies to support people living at the service. This included the speech and language therapy team.
● Staff contacted healthcare professionals appropriately. We observed doctors being contacted on the day of our inspection and medical advice being sought.
● We received positive feedback from one healthcare professional who told us, "The staff are very pleasant, very helpful. They follow our advice and take on board what we say. There have been no negative comments from the team regarding this home, I would say they are caring."

Requires Improvement

Is the service caring?

Our findings

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

At our last inspection we rated this key question good. At this inspection we have rated this key question requires improvement.This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- Staff did not always seek the views of people before providing care. For example, there was no evidence that one person who wanted to get out of bed was supported to do so and for one person who wanted to go outside could not.
- People and relatives told us people's basic needs were met however, people told us they did not have bath or showers. The records for six people showed people had bed baths and had not been offered a choice.

The provider had not ensured people received care and treatment that was appropriate, met their care needs, including social and leisure needs and reflected their preferences. This had placed people at risk of neglect. This was a breach of regulation 9 (Person centred care) of the Health and Social Care that Act 2008 (Regulated Activities) Regulations 2014.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- People and relatives told us staff were kind and caring and knew their basic care needs well. Comments included, "They are amazing and fantastic with everyday care", "Fantastic care, can't fault what they do" and, "Staff here are good."
- We observed staff interacting with people in a caring way. Staff spoke to people with warmth and affection and treated people with kindness and respect.
- Staff knew people well. One staff member said, "What I like best is talking with them. [Person] loves reading, and I brought them in some books to read. I enjoy that side of it. [Person] likes to have a little joke."
- Staff did not always have time to spend with people due to the tasks they had to complete. The afternoon was quieter, and people were left unoccupied for long periods of time. One staff member said, "The high level of dependency people against staff numbers means we may be unable to meet every need as quickly as we would like."

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question requires improvement. The rating for this key questions has remained requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

At our last inspection we found systems were not in place or robust enough to demonstrate person-centred care was effectively managed. This was a breach of regulation 9 (Person centred care) of the Health and Social Care that Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the provider remained in breach of regulation 9.

● At our last inspection we identified care plans did not provide enough detail to ensure people's care needs and preferences could be consistently or safely met. We asked the registered manager what had been put in place since our inspection to improve, the registered manager said, "I am not sure, I would need to look at the report." We found no improvements had been made since our last inspection.
● Care plans had not been completed with people and/or their representatives. Care plans did not contain enough person-centred information to support staff how to meet people's needs. For example, one care plan stated, "not always able to communicate needs" The person had a medical condition which made it difficult for them to communicate, this was not reflected in the care plan and staff had not been given instructions on how to support the person to communicate and allow them to express their views.
● People were not always involved in decisions about their care. For example, people were being cared for in their beds when there was no reason for this and not always the person's choice. On the first day of the inspection the registered manager told us "[people were] all bed bound upstairs." We spoke with people and received comments including, "I would like to get out of bed", "No! I don't like staying in bed" and, "I wish I could get out of bed more often; I don't really like being in bed all the time." Assessments had not been undertaken to determine people's abilities. This meant peoples' independence and mobility was also not promoted or maintained which put people at risk of harm due to immobility.
● One relative told us, "Since February [person] has not been out of bed which is a concern as in hospital they were getting out of bed." We fed back our concerns to the registered manager who said the local authority had visited to support staff to assist people out of bed since our first day of inspection. More people were assisted out of bed by the end of our inspection.
● The service did not meet peoples' individual needs in relation to maintaining interests and hobbies, maintaining relationships or contact with the community. People told us they had not been asked about their hobbies and interests and there was a lack of stimulation. Comments included, "They (staff) do not do any activities here, no they have not asked me my hobbies and interests", "No they do not do activities here. It would be nice to get out of day trips" and, "Activities? no there isn't anything like that!"
● People were not always able to access the garden if they wanted to. We received comments from relatives including, "Trouble is, it is difficult to take [person] into the garden, you can't get into their room with a

wheelchair" and, "Once you're upstairs that's it, you can't really get about." We discussed this with the registered manager who told us one person upstairs couldn't come down as the wheelchair would not fit in the lift and agreed one room was too small for wheelchair access. This room was no longer in use and plans were in place to turn it into a staff office.

● Two people living at the service were transferred in the lift on a commode. The registered manager told us the smaller size of the commode meant it fitted in the lift. They had not taken action to explore a more dignified way of transported people in the lift, for example a small wheelchair.

The provider had not ensured people received care and treatment that was appropriate, met their care needs, including social and leisure needs and reflected their preferences. This had placed people at risk of neglect. This was a breach of regulation 9 (Person centred care) of the Health and Social Care that Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● Staff had not always been made aware of people's communication needs and were not always certain of peoples' mental capacity status.

● Staff did know whether people needed glasses or hearing aids we observed staff place one person's glasses within reach so they could read. If needed information could be provided in large print, picture format or a language other than English.

End of life care and support

● There was no one requiring end of life support at the time of our inspection

● Staff had completed end of life care training and felt confident they could support a person at the end of their life.

● The registered manager told us, "We call the end of life nurses and work with them when someone is near the end of their life, they are brilliant."

Improving care quality in response to complaints or concerns

● People and relatives knew how to complain and felt they would be listened to.

● A complaints policy had been rewritten since our last inspection to include the right to appeal and to whom however, this had been handwritten and was waiting to be formally typed up and not yet put into use.

● No complaints had been recorded since 2017 and the registered manager confirmed no formal complaints had been received since our last inspection.

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

At our last inspection we found systems were not in place or robust enough to demonstrate good governance. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the provider remained in breach of regulation 17.

- There were no robust systems and processes in place to monitor the quality and safety of the service. The provider did not complete any governance checks such as quality monitoring audits. For example, relating to care plan reviews, medicines management and accident and incidents.
- There had been no improvements since the last inspection. The provider and registered manager had not ensured robust systems and processes had been put in place since our last inspection which had led to the shortfalls found in this inspection including keeping records to provide consistent and safe person-centred care, identifying and managing risks, providing support to people in a restrictive way, governance and having sufficient staff to meet people's care needs placing people at risk of harm.
- The service did not ensure a robust system was in place for accidents and incidents to be recorded and reviewed for themes and trends to identify lessons to be learned and drive improvements.
- Records relating to the care and treatment of each person using the service were not kept securely and confidentially in line with the data protection act. Records were accessible to any visitor coming into the home.
- Quality assurance surveys had not been used to formally gather feedback from people, relatives and staff to identify areas of improvement.

We found no evidence that people had been harmed. However, systems were not in place or robust enough to demonstrate good governance. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we found notifications of incidents had not been sent to us in line with regulatory requirements. This was a breach of f Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. At this inspection we found improvements had been made and the provider was now meeting this regulation.

● Notification of incidents had been sent to us in line with regulatory requirements.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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

● People and relatives told us they felt comfortable to speak with who was in charge. However, they were not always clear on who the registered manager was because they were not in the home every day. One staff member said, "I feel having all of management based at the other care home can make it feel we are out on a limb and there is a delay in addressing our issues, not just for staff but our residents too."

● However, staff felt listened to and supported. One staff member said, "I feel supported, I am very comfortable to go to management team. They listen to me. Staff morale is good, we all get on well which is important. Yep, it is a good place to work. This is a very homely environment."

● Staff had completed training in equality and diversity. However, the service did not have a pre assessment process that supported exploring people's protected characteristics. The registered manager said they would speak to people to see if they were comfortable to share their protected characteristics and treat everybody the same.

● The registered manager was open and honest throughout the inspection. People and relatives told us the registered manager was open and told them when things went wrong. One relative said, "They phoned when [person] had a fall, they tell us all the time and don't keep us in the dark."

Working in partnership with others

● The service worked in partnership with healthcare professionals, this included a regular visit from a healthcare practitioner.

● The service was working with the local authority at the time of the inspection who were recommending improvements to the service.

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	Regulation 11 HSCA RA Regulations 2014 Need for consent The care home had not ensured care and treatment was only provided with the consent of the relevant person. The requirements of the MCA had not been followed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was not sufficient numbers of staff to make sure people's care and treatment needs were always met.

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 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured people received care and treatment that was appropriate, met their care needs and reflected their preferences

The enforcement action we took:

We issued a notice of proposal with positive conditions that the provider and registered manager had to meet.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to assess, monitor and mitigate risks to the health and safety of all the people using the service. Medicines were not always managed safely.

The enforcement action we took:

We issued a notice of proposal with positive conditions that the provider and registered manager had to meet.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People had been placed under unnecessary restraint. This had impacted on their ability to choose how they wanted to live their lives.

The enforcement action we took:

We issued a warning notice so action could be taken as soon as possible to improve the lives of people using the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not in place or robust enough to

demonstrate good governance.

The enforcement action we took:

We issued a warning notice so action could be taken as soon as possible to improve the lives of people using the service.