Athena Healthcare (Coombe Valley) Limited

Willow Park Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Willow Park Lodge Care Home is a residential care home providing personal and nursing care to 49 people at the time of the inspection. The service can support up to 79 people.

The service is provided in a purpose-built building which is split over four floors, however at the time of the inspection the fourth floor was not occupied. People who lived with dementia were accommodated on the second floor. At the time of the inspection there were 23 people living on the second floor.

People's experience of using this service and what we found
Relatives told us that the service had been very poor, but the new manager had made some improvements and they were hopeful things would continue to improve. Comments included, "It went downhill quickly. It was heart breaking. Just coming in today I have noticed a change already. It's tidier." And, "We've not been very happy but now it is a lot cleaner, the staff are happier. There are a lot of agency, but we are hoping that things will improve."

Management of the service had been exceptionally poor, and the providers had lacked oversight. Communication between staff needed to be improved. Records were absent for a large portion of the previous year including records of safeguarding and incidents. The nominated individual told us that some records had been deleted from the system without the providers agreement.

Incidents had not been well investigated and some safeguarding concerns had not been reported to the Care Quality Commission (CQC) or the local authority at the time they occurred. Since the deputy manager took over running the service concerns had been reported to safeguarding where appropriate. However, there continued to be concerns about reporting safeguardings to the Care Quality Commission (CQC).

There had been no regular audits of the service. When concerns had been identified the provider had not acted in a robust and timely manner to ensure that these were resolved quickly and that standards of care were improved.

Staffing levels had fallen to very low levels and at the inspection, they had been increased again. However, we found they still needed to be improved. Staffing levels have been increased since the inspection. However, we were unable to assess the impact of these changes and if improvements had been sustained.

Staff training needed to be improved to ensure that staff had the skills and confidence to meet people's needs safely and effectively. Staff had not always been well supported.

The management of medicines needed to be improved. Although they were well organised, and records were complete, staff administering medicines were also responsible for receiving and making phone calls. This meant on some days some medicines rounds were long and there was a risk doses would be given too

close together.

People's needs had been assessed. However, assessments had not been used to plan staffing levels or ensure that staff had the training they needed to meet people's needs. Risks to people had not been well managed and there was a lack of monitoring in place. The monitoring of people's hydration needed to be improved. Risks from the environment needed to be addressed including developing an appropriate action plan to resolve some concerns raised by the local fire and rescue service. Care plans were not up to date, and staff told us they had not had the opportunity to spend time reading care plans.

Staff lacked the time to provide person centred care and support people in a dignified manner. People were not always treated as well as they should have been. However, people told us most staff were kind and caring.

The environment needed improvement to ensure it was more dementia friendly and in line with best practice guidance. Feedback about the food was mixed. However, most people said the food was nice. People told us they had not been asked for their feedback about the food.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. Capacity assessments for specific decisions had not been completed and there were no records of decisions being made in people's best interests.

People and their relatives had not been consulted about their views. However, the new manager had started to make improvements in this respect. There were no records of some complaints made.

There was a schedule of activities. However, there was no evidence that people had been consulted about these or offered an alternative activity if they did not want to attend a group activity that day. There were no records of staff spending social time with people who were cared for in bed or spent most of their time in their room.

A new manager had been recruited who started at the service the two days prior to the inspection. The new manager was supported by a deputy manager. The new manager had started to make improvements to the service.

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 Good overall and Requires Improvement in Well-Led (published 01 June 2018). However, there were no breaches of regulation at the last inspection and the provider was not required to submit an action plan to show what they would do and by when to improve.

At this inspection we found the service had deteriorated and there were multiple breaches in regulation.

Why we inspected
The inspection was prompted in part due to concerns we received about the management of the service and standards of care. A decision was made for us to inspect and examine those risks.

Enforcement
We have identified breaches in relation to risks to people, risks from the environment, staffing levels, staff

training, consent, person centred care, complaints, treating people with dignity, management, reporting concerns to the Commission.

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

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

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. 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**

Willow Park Lodge Care Home

Detailed findings

Background to this inspection

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

Inspection team
This inspection was carried out by three inspectors. One inspector visited the service on three days, one inspector attended for two of those days and a third inspector attended for part of the final day.

Service and service type
Willow Park Lodge Care 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 both were looked at during this inspection.

The registered manager was no longer employed at the service at the time of the inspection. However, they remained registered with CQC. 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 the inspection a new manager had been recruited and had started in post that week. However, they were not yet registered with CQC.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is

information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We reviewed information we had received about the service since the last inspection. We received feedback from social care professionals. We used all this information to plan our inspection.

During the inspection
We spoke with 16 people who used the service and four relatives about their experience of the care provided. We spoke with 14 members of staff including the new manager, deputy manager, the nominated individual, senior care workers, care workers, laundry staff, hostess staff, agency staff and the chef. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included nine people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed. We spoke to one visiting health and social care professional.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and other records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

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

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

Learning lessons when things go wrong

● Incidents were not well investigated and there was a lack of learning from incidents. Changes had not always been made to people's support to reduce the risk of incidents occurring. One social care professional said, "The quality of reporting varies quite significantly. There are some very accurate detailed reports but others basic and lacking relevant information."

● Incident records were brief and had not taken in to account the circumstances surrounding events. For example, one person who had a catheter had a urine infection and the symptoms noted were confusion and hallucinations. They had a series of falls over a number of days and changes in emotional based behaviour. Two of these falls resulted in them being taken to hospital. They were also moved floor after the first trip to hospital which could have an impact if the person was confused. The incident investigation had not looked at the person's fluid records or considered if the urine infection or move increased the risk of falls and unusual behaviour. The person's fluid intake and urine output had not been consistently recorded. The person care plans and risk assessments were not updated and did not include information on the signs and symptoms of the person's urine infection. During the inspection the person was still in hospital following the last fall. Their relative informed the service that they had been found to be dehydrated and had low blood sugar, both of which may have contributed to the falls and behaviours.

● At the time of the inspection there was no evidence that the service used tools such as ABC charts following incidents of emotional behaviour. ABC charts record learning about people's triggers and what actions had been successful in supporting the person to feel calm. During the factual accuracy process we were sent a record for one person. However, we were not assured that these charts were used widely within the service, where appropriate. We will review this on the next inspection.

● There was evidence there had been some incidents in September and November 2019. However, there were no records of these events at the inspection. Following a complaint, in December 2019 the November incident was investigated by the provider. The provider found that 'investigation paperwork could not be found for either incident'. The nominated individual told us that records had been deleted from the system without the providers agreement. The provider's investigation found that the registered manager failed to investigate the incident in November 2019. There was no information in the investigation to enable the inspector to establish if the incident in September had been investigated or not.

The provider failed to ensure that risks to people were sufficiently monitored, and that action was taken to reduce risks. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

● Risks to skin integrity had been poorly managed. For example, one person was cared for in bed and had a

pressure sore. The district nurse had been out to dress the wound; however, no turning charts were put in place for this person or any other person cared for in bed. Another person had an airflow mattress in place. Staff told the inspector that they were developing a pressure sore on their ankle. These mattresses are set according to the person's weight and are to reduce the risk of pressure sores developing. However, there were no records that the person had been weighed since August 2019. This meant staff could not be certain that the mattress was at the correct setting. We spoke to the new manager about this concern. Turning charts were put in place on the day of the inspection and the person's weight was checked to ensure that the pressure mattress as set correctly.

● Risks to people had not been well managed or monitored. For example, some people were on 15-minute observations. However, these had not always been undertaken.

● Care plans and risk assessment were not easily accessible to staff. These were stored electronically, and staff only had access to one computer on each floor. Staff told the inspector, "It can be difficult to find the time to sit and read these. It would be easier if we have a hand held or paper file rather than having to wait and log on" and, "I didn't get to read the care plans. I am still learning about people now as I have not sat and read the care plans." Some staff were new and agency staff were working at the service. This meant there was a risk that staff did not know about people's needs and risks.

● After the inspection the new manager put a process in place to improve organisation and clarify people's support needs. This included assigning care workers to specific people to ensure that monitoring was not missed due to miss communication. However, we were unable to assess the impact of these changes and will follow this up at our next inspection to see if the change has led to sufficient improvement.

● Some people had emotional based behaviours that could lead to them putting themselves or others at risk. There was a lack of behaviour management plans for some people. This meant there was a lack of guidance for staff on how to support people to remain calm.

● Risk assessments needed to be improved and there was a lack of detail in risk assessments. For example, one person had a catheter and there was no information on the signs and symptoms of infections to ensure staff identified concerns.

● There were risks to people from the environment. Prior to the inspection the fire service undertook an inspection and raised a number of concerns about the building and the support people were provided with respect to fire safety. The provider had addressed a number of these concerns. However, some concerns had not yet addressed and there was no timescale on the action plan as to when these would be resolved. For example, to ensure that emergency lighting was regularly tested.

● People had personal emergency evacuation plans in place. These provided information about the support people need to evacuate the building. However, the staff we spoke to on inspection did not always know where these were. On one floor they were kept in a grab bag and on another other floor they were not. This meant it was confusing for staff and there was a risk staff would not find these in the event of an emergency. Fire drills had been undertaken and fire alarms were tested weekly. However, there were no records to evidence fire extinguishers were being checked regularly at the time of the inspection.

● There were no records of hot water temperature checks to ensure that water was at an appropriate temperature to reduce the risk of waterborne infection. However, the water system was tested for legionella in January 2020 and no concerns were found and cleaning staff were regularly flushing the water system to reduce the risk. There was a gas-powered tumble dryer and there were no records of safety checks having been completed. We raised this with the new manager who arranged for the tumble dryer to be checked immediately after the inspection.

The provider failed to ensure that risks to people were sufficiently monitored, and that action was taken to reduce risks. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● People were not always kept safe from the risk of infection. For example, three people on one floor used a hoist. One person had their own sling due to their physical needs. However, the other two did not and slings were shared. These slings should not be shared between people as there is a risk of transference of infection.

● An Infection control audit was undertaken on 10/01/2020. This identified the need for weekly cleaning of wheelchairs and walking frames. However, there were no records of this having been done. Some people had mattress protectors and the last record of these being checked and cleaned was 19/07/2019.

● Staff did not always follow good infection control practices. For example, we observed one agency staff carrying dirty laundry, they were holding the laundry against their tunic and were not wearing an apron. This meant there was a risk of infection transferring on to their clothes and then being passed on to another person through contact. This was a particular concern as the home had recently had an outbreak of norovirus.

The provider failed to ensure that risks to people were sufficiently monitored, and that action was taken to reduce risks. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● Medicines were not always managed well. Medicines were administered by senior staff. However, they were also responsible for answering telephone calls throughout the day including when they were administering medicines. This meant on the first day of the inspection the morning medicine round took over 3 hours and there was a risk that people did not get their medicines on time and may not have had the required time between doses.

The provider failed to ensure medicines were well managed. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Medicines were stored safely and kept secure. Medicine administration records were complete and accurate. For example, the count of medicines in the records matched the number of medicines in stock.

● There was information on what people's medicines were for and how they wanted to be supported to take them. Where people had 'as and when' medicines, such as pain relief, there was guidance for staff in place. For example, how often these medicines could be administered during a 24-hour period.

● Staff received training to administer medicines and their competency was checked regularly.

● Some creams and liquids only remain effective for a period of time after they are opened. Creams and bottles of liquids were dated so staff knew when they should no longer be used.

Staffing and recruitment

● There was insufficient staff to support people and staffing was not well organised. Whilst some people were positive about staffing levels others were not. Comments included, "I don't think there is enough staff sometimes they are very rushed. If there were more staff, they would be more organised" and, "Staff are a bit rushed and sometimes are short with us. I don't think it is well organised, anybody seems to do any task." Staff said, "We struggle at times. The paperwork gets lacking, we try and do it all, but the person's care is more important, so the paperwork gets neglected" and, "We are spread quite thin."

● One person told us they felt anxious but had no one to talk to. They said, "The staff are very good, and I sit with them and have a chat, they are so busy they can't stay with me long. The staff are helpful but just don't have time. They always seem busy."

● There was a dependency tool in place. However, this had not been updated when new people had moved

in to the service and people's needs had changed. For example, one person's care plan said they needed support from one member of staff. However, staff said they now needed support from two staff. One health and social care professional said, "There have been occasions where I would walk up and down the corridor and could not find any staff.

● Staff did not always have time to meet the needs that were recorded in the dependency tool. For example, the inspector spent 20 minutes observing one person who should have been checked by staff every 15 minutes. During this time the person was alone in a room with another person. Both people had been assessed as needing immediate intervention from staff for behaviour that challenged. During this time no care staff checked on them as they were busy elsewhere. One staff member said, "It's getting better, but it's hard to do things like checks every 15 mins."

● We raised this with the new manager who had started at the service that week. They agreed that the dependency tool needed review and that staffing levels needed to be increased. After the inspection the manager met with the provider and staffing levels were increased. Staff were also allocated to support specific people to improve organisation. However, we were unable to assess the impact of these changes and if improvements had been sustained. We will review this at the next inspection.

The provider had failed to ensure to maintain sufficient numbers of staff to meet people's needs. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● The staff working at the service at the time of the inspection had been recruited safely. Checks had been undertaken to make sure staff were suitable to work with vulnerable people before they started. For example, appropriate references were sought and Disclosure and Barring Service checks had been completed which helped prevent unsuitable staff from working with people who could be vulnerable.

Systems and processes to safeguard people from the risk of abuse

● Systems and processes had not been operated effectively to prevent the risk of abuse and ensure that concerns were investigated in a timely manner by the appropriate authorities.

● Concerns had not always been reported to the local authority safeguarding team when they should have been. For example, one person had not been provided with appropriate levels of care whilst living at the service and was admitted to hospital. Following a complaint to the provider about the incident the providers undertook an investigation. The investigation identified the registered manager failed to investigate the incident and report it to safeguarding. The providers investigation found that the concerns were substantiated. The staff involved in the concern no longer worked for the service.

● Staff told us that they had had concerns about poor practice at the service and in particular concerns about staffing levels during the autumn. However, staff had not felt confident to blow the whistle. However, since this time some staff had updated safeguarding training and said they felt more confident to raise concerns with the local authority or the Care Quality Commission in the future.

● Since the deputy manager took over running the service, concerns had been reported to safeguarding where appropriate. Feedback from the local authority was that the deputy manager 'Has been good at responding to enquires and providing information.'

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

● Staff training needed to be improved to ensure that staff had the knowledge they needed to support people. The training offered was basic and did not meet the needs of people. For example, one person's care plan stated they had seizures. The action in the risk assessment to reduce risk was to ensure that staff had full training in the care of seizures. Staff had not had this training.

● Staff had not completed training in nutrition and hydration and were supporting people with dementia where poor eating and drinking is a risk. This was particularly concerning following an incident where one person had not been adequately supported with fluid and food. Staff had completed training in supporting people with dementia, however they had not done training in behaviour that challenged. There was no evidence that staff had completed training in specific needs such as catheter care and diabetes awareness. There were gaps in staff training and not all staff had completed the training they needed including, health and safety, the Control of Substances Hazardous to Health, first aid and food hygiene.

● Staff who had been there for some time had some understanding of how to support people with risks, however, there were areas where they had not. For example, staff had not recognised that one person's low fluid intake and urine infection could impact on their risks and behaviour. There was a significant number of new staff starting with the service and there was a risk that they would not know how to support people appropriately without access to training.

● Staff were not confident in their roles at times. For example, one person was upset and wanted to leave the room they were in. Staff were not able to get the person's wheel chair footplate to click in to place. The person was becoming more distressed and staff asked the inspector for advice on what to do so they could move the person. One person said, "Staff here are inexperienced, they say they will do something but go off and don't come back because they don't know how to do something".

● Staff had not always undertaken an appropriate induction to the service. However, the deputy manager and new manager were resolving this concern and new staff were in the process of being inducted appropriately and undertaking shadowing of a more experienced member of staff. The deputy manager had supported staff and undertaken staff supervisions. There had also been group supervisions following specific incidents.

The provider had failed to ensure that staff had suitable training to enable them to carry out their role effectively. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The deputy manager had recently undertaken competency checks for medicines to ensure staff knew how

to support people safely. The deputy manager told the inspector that staff competency for manual handling had been undertaken. Records for manual handling competency checks were not available at the inspection. However, the nominated individual told us that some records had been deleted from the system without the providers agreement. We did not observe any poor manual handling practice and staff had received training.

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

● People's oral health needs were assessed. However, these assessments were not always well completed and there was a risk that people were receiving poor support with dental care. For example, one person was admitted to the service on 11/07/2017. Their oral care assessment dated 04/12/2019 stated staff did not know how old the person's dentures were. The person had some remaining teeth and staff did not know when they last saw a dentist and the person was not registered with a dentist. The new manager was arranging oral healthcare training for staff to assist with improvements.

● Staff told us when people were unwell, they contacted the GP. However, staff did not regularly access peoples' care plans and risk assessments and there were gaps in staff training. This meant there was a risk that staff would not have the knowledge they needed to recognise when someone with an existing condition was unwell.

The provider had failed to do all that was reasonably possible manage and mitigate risks to people's health and safety. This is a breach of Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There was evidence that people had accessed healthcare. For example, some people had seen the dietician, the GP had been contacted when some people were unwell, and the nurse had visited. One person coughed when they took their medicine and staff had a discussion with them about a referral for a swallow assessment. Other people had had these assessments and one person was waiting for the visit from the assessment team.

Ensuring consent to care and treatment in line with law and guidance

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

● There were no records of any capacity assessments for specific decisions. There were no records of any best interest decisions being made on people's behalf. This meant the service could not demonstrate that it had complied with the MCA where people did not have a legally authorised decision maker in place under the MCA.

The provider had failed to ensure that care was provided in line with the Mental Capacity Action 2005. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Where people were deprived of their liberty applications had been made to the DoLS office for authorisation. There were records to demonstrate where relatives had power of attorney, they had the legal authority to make decisions on people's behalf.
● Staff understood that people with capacity had the right to make decisions for themselves.

Supporting people to eat and drink enough to maintain a balanced diet
● Where people were at risk of choking, they had been assessed by the speech and language team and plans were in place to ensure people had the support they needed to eat safely. For example, one person needed staff supervision whilst eating and we observed that staff did this. However, their care plan stated that they were to be weighed weekly and the last recorded weight for the person was in August 2019. This meant staff would not know if the person was losing weight. We raised this with the new manager who ensured that the person was weighed.
● People were offered regular drinks throughout the day. However, people's fluid was not well monitored. For example, one person had 800ml of fluid recorded in total for the day. Staff documented in the daily notes that the person had had a good fluid intake. We asked staff what a good or poor intake was for the person. Some staff were not certain and there was no target total in the person's care plan or on the fluid charts to provide guidance.

The provider failed to ensure that risks to people were sufficiently monitored, and that action was taken to reduce risks. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Feedback about the food was mixed. Some people told us that they thought the food was good and comments included "The food is very good never had any issues there, and they cater for a soft diet" and, "The food is home cooked, and the cook is very good, get choices varied menu, nice puddings." However, the food was prepared in one kitchen and served throughout the home from a heated trolley and some people were unhappy with the temperature. Other comments included "The food not very hot, it's alright, get choices of meals" and, "I don't think they put enough thought into food, it's served on cold plates, the food is lukewarm and there's not enough veg." After the inspection, during the factual accuracy process, the provider informed us that they had taken action to address concerns about food temperature. We will review this at the next inspection.
● People chose their meals the day before. However, there was no menu on display and some people could not remember what they had ordered. Some people were not aware that they could change their minds and ask for an alternative meal on the day.
● We saw some positive examples of people being supported to eat well. For example, one person declined to eat their lunch. Staff waited for a while and offered the person lunch again. When the person declined staff tried again and offered different options until they found something the person was happy to eat.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs had been assessed. However, assessments had not been used to plan effective care and support. We spoke to the new manager about this who agreed that these concerns needed to be addressed and adjustments to staffing and training needed to be made prior to people moving in to the service. The new manager advised that a new pre-admission assessment was to be developed. We were provided with a copy of the new pre-assessment during the factual accuracy process. However, as the service introduced this after the inspection, we have not been able to determine the impact of this new process or establish it has led to improvements. We will review the effectiveness of the new pre-assessment at our next inspection. The nominated individual wrote to us to inform the inspector that intake at the service would be paused whilst the new manager settled into their role.

● Best practice tools were used to support the assessment of people's needs. For example, tools to assess the risks to people's skin integrity. These had been kept up to date. However, these were kept electronically alongside people's care plans and risk assessments so staff access to these was limited.
● Assessments also looked at needs relating to people's protected characteristics under the Equality Act 2010, which includes disability, sexual orientation, or religion.

Adapting service, design, decoration to meet people's needs
● Some people at the service were living with dementia. There was signage in place such as room signs and door numbers to assist people to find their way around. However, best practice guidance includes that dementia friendly environments should introduce noticeable landmarks that might have special meaning to people and can be used as reference points. At the inspection we found the use of landmarks needed to be improved to assist people with navigation. During the inspection we saw several people who told staff they were lost and needed support to find their room or the bathroom. We raised this with the new manager who agreed that improvements needed to be made.
● The corridors were wide and free from clutter; the doors were wide. This meant people who needed to use wheelchairs could get around safely. Each person has their own en-suite facilities including a shower and there was a fully adapted bathroom available in each unit.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- The provider had not ensured that people had been well treated. For example, systems to keep people safe from harm and protect them from risk were not robust. There was a lack of staff to support people.
- People's dignity was not always maintained. For example, their property was not always respected. The new manager met with relatives the day before the inspection. One of the concerns raised was the level of lost property that had accumulated at the service with people's items and clothes not being identified as there's. One the first day of the inspection we observed one person wearing slippers that did not fit. Staff were supporting the person to move using a wheelchair and noticed that the slippers they were wearing were not theirs. The slippers were removed and left on the side and were still there on the last day of the inspection.
- People were not always supported to be as independent as they could be. Care plans were not clear on what people could do for themselves and there was a risk staff, including new and agency staff, would not know how to promote people's independence. For example, one person's personal care plan stated they needed prompting with changing continence aids. However, their continence plan said they needed staff assistance.
- Most staff were kind, caring and dedicated to the role. However, there were a lot of new staff and agency staff were used. Feedback from people was mixed. People said, "Staff are kind they can't do enough for you. Have good banter with the staff lots of humour." And, "The staff are very nice and very good. They have got to know me well, know how I like things. They have to tell the new ones or agency." 'However, another person told us, they were unhappy that some staff did not address them by their name.
- Staff did not always knock when entering people's rooms.

The provider had not ensured that care was provided in a way that supported people's dignity. This was a breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Peoples equality needs had been assessed and there were some measures in place to meet these. For example, where people wanted to practice a religion they were supported to do so and had access to religious services. People's records were kept securely to protect their confidentiality.

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

- Staffing levels had an impact on how staff were able to respond to people's decisions. For example, one person was distressed, they needed staff support to mobilise and told staff they wanted to sit somewhere

quiet but have a staff member with them. Staff were not able to offer this support and the person was sat in the lounge which was very busy.

● People had communication plans in place. However, staff did not have regular access to care plans and there were no records to demonstrate that care plans had been updated. For example, one person was living with dementia, communication plan was dated 20/12/2017. There were no records to evidence that this had been reviewed. This meant there was a risk that staff had not ensured that the information was up to date and remained accurate.

● Staff were rushed and did not have time to spend with people to sit and listen to them. During the inspection we observed staff spent significant portions of their time sat in the lounge completing paperwork and not engaging with people.

The provider had not ensured that support provided to people was person centred. This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated Requires Improvement. This meant people's needs were not always met.

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

- Staff were not always aware of people's preferences. There was a significant number of new staff at the service and the service used agency staff. This meant that not all staff knew people well and there was a risk that care would not be person centred. Some preferences for people were recorded. However, staff did not have regular access to these. This meant staff were not always aware of people's preferences. For example, one new member of staff was asking one person what they wanted to eat. They offered the person meat-based choices as they were not aware that the person was vegetarian.
- Some information in people's care plans needed to be updated and there was a risk that staff would not know how to support the person's individual needs. Staff told the inspector one person had a hernia and this impacted on the support they needed to use the toilet. However, this was not clear in the person's care plan and staff said the person was now in need of more assistance.
- People's needs were not always fully considered or accommodated. For example, one person's bed was too short for them. Staff used a pillow to prevent the person's feet from rubbing against the footboard. However, this was not a long-term solution and needed to be resolved.
- Care was not always personalised, and the low levels of staffing was a restriction on some people. For example, one person told the inspector they liked to smoke but they found it difficult because they had to find staff to support them to go outside to do so. We observed staff went out themselves to smoke, but no arrangements had been made to offer this support to this person.
- There were end of life care plans in place for some people. These contained some information such as what treatment the person wanted at the end of their life and how they wanted to be buried. However, other people did not have sufficient plans in place. For example, one-person's plan created on 24/03/2019 lacked detail and said that staff were to meet with the family to discuss. This had not been documented as done.

The provider had not ensured that support provided to people was person centred. This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- There were two activity co-ordinators at the service. However, activities needed to be improved. There was a program of activities which some people participated and enjoyed. For example, In the morning some people went to the ground floor to participate in groups activities in the main lounge downstairs for chair-based exercises. There was also a tea party on the ground floor on the Friday which people and their relatives enjoyed.
- Where people did not want to participate in these activities, there was no evidence they were offered an

alternative and we observed people sitting in the lounge without stimulation for significant periods of time. There were no records of what time staff were spending with people in their rooms when they were cared for in bed. This meant people were at risk of social isolation. We saw days were no activities were recorded for some people at all.
● There was no evidence that people had been involved in planning the activity program and some care plans contained little information about what people liked to do.
● The new manager agreed that activities for people needed to be improved and had begun looking at ideas for more external activities and trips out for people.

The provider had not ensured that support provided to people was person centred. This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us their relatives were free to visit when they wanted to do so.

Improving care quality in response to complaints or concerns
● We were unable to fully assess if complaints received by the service had been appropriately investigated and responded to as the majority of records were not available at the inspection. There was evidence that complaints had been received, however, there were no records of some of these. For example, there was only one recorded complaint between June and December 2019. The complaint stated that it was the second complaint made by this relative. There was no record of the first.
● We looked at complaints received by the provider. However, the information received was incomplete and further detail was not available. For example, there were two complaints made in October 2019 about 'Management issues. There was no information on what these management issues were. The recorded resolution was for the person complaining to meet with the manager to resolve concerns. We were not able to establish if complaints had been resolved appropriately.

The provider had failed to operate an effective accessible system for receiving, recording, handling and responding to complaints. This was a breach of Regulation 16 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● A complaint about the temperature of the food was received by the provider on 06/01/2020. At the time of the inspection there was no recorded resolution and people raised similar complaints with the inspector at this inspection. After the inspection during the factual accuracy process, the provider informed us that they had taken action to address the concern. In that, a second hot trolley has been purchased; plates are warned when requested; and food temperatures were being checked.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● People's communication needs had been assessed and the new manager understood the obligations of the AIS. However, there was no evidence that some communication plans had been reviewed or updated regularly.
● Accessible information was limited. For example, there were pictures in place to assist people to choose the food they wanted. However, information such as care plans and the complaints policy were not available in large print for people who needed this. The new manager agreed this was an area for improvement.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

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

At the last inspection we recommended the provider ensured that quality monitoring systems were embedded and reviewed to sustain improvements. At this inspection we found quality monitoring had deteriorated.

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

- The standard of service provided to people had been poor and the registered manager and provider had failed to achieve good outcomes for people. The quality of service had significantly fallen during the autumn 2019. At the time of the inspection there were nine care workers on shift during the day and we found that this was not sufficient. However, in the autumn staffing levels had been even lower. For example, we looked in detail at a four-week period in October, when there was around 40 people living at the service. During this period staffing was a mainly seven care workers a day. There had been 12 days were staffing numbers were lower than seven including three consecutive days where it had been as low as four. This included agency staff. This meant the registered manager and provider had failed to effectively monitor staffing levels and act when there were significant concerns.
- Staff had been let down by the registered manager and the provider. Some staff spoke about times they had been in tears or run ragged because of management failures. A staff member who had been at the service for over six months said, "I have only just been given the induction booklet. I came and did three shadow shifts and was thrown in a deep end. I didn't get to read the care plans. I started with no training, no one assessing me or making sure I was competent to do the job. One weekend it was only me and agency staff and I had to explain everything to them. I was going home in tears and shattered." Another member of staff commented, "A lot of staff left, and we ended up thin on the ground, it was stressful."
- After the registered manager left the service the day to day management had been undertaken by a dedicated deputy manager who had made improvements to areas such as staffing levels and medicines management. However, they had not been in the role for long, and had not been offered training nor were they adequately supported by the provider. This meant that some concerns were not addressed as quickly as they could have been had the provider taken more action and ensured the resources were in place.
- The provider was not able to evidence that they had recruited the registered manager safely. References had been sought and received but were not on headed paper nor included a company stamp as per the providers policy. The provider was not able to evidence that these references had been validated.

The provider had failed to assess, monitor and improve the quality and safety of the services. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities)

2014.
● At the time of the inspection a new manager was in place having started at the service the week of the inspection. The new manager had begun to make improvements. For example, prior to them starting in post staff had limited access to handover notes. This meant staff did not always have information on what happened at the service if they were away for more than a day. This concern was addressed by the new manager.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
● The provider had lacked oversight of the service, particularly as the registered manager had been new to the service. The provider had failed to identify concerns in a timely manner and before they had an impact on people.
● In response to complaints by relatives an audit of the service was undertaken on 25/11/2019. This identified significant concerns. For example, poor cleanliness, a lack of evidence of environmental safety checks, a lack of induction for staff, and a lack of records, a high level of medication recording errors, staff training was not up to date and there were no incidents records. After this audit the registered manager left the service and some improvements had been made.
● There were no service audits, other than the provider audit, available at the inspection from July 2019 to January 2020. From January 2020 audits of medicines and infection control had been completed. However, there continued to be no audits of fluid and food charts, observation charts, turning charts, care plans and risk assessments.
● Records of safeguarding's, incidents and complaints relating to the period where the registered manager was at the service were not available. However, there was evidence that these had occurred. Daily notes and other monitoring records were disorganised. Some records were stored in a file which was overfull, and records were falling out. Records from the days before the inspection were all mixed together in one large pile and staff were not able to find records when the inspector requested these.
● Concerns which had been identified had not been addressed in a timely manner. For example, at the time of the inspection, there was a hole in the laundry room ceiling. Records showed it had been there for at least 12 months and it had not been addressed. We raised this with the new manager. After the inspection they wrote to us to inform us that it had been repaired.

The provider had failed to assess, monitor and improve the quality and safety of the services. The provider had failed to maintain complete, accurate and contemporaneous records. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● Notifications relating to safeguarding's which had occurred at the service were not submitted to the Commission in a timely manner as required.

The provider had failed to ensure that notifications were submitted to CQC when there was a notifiable event. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● There were no records of surveys having been completed for people or their relatives. One person told us, "I've been here just under a year, no one has ever asked me what I think about the meals or asked for a favourite meal".
● There was no evidence that there had been regular meetings for relatives or residents. At the time of the inspection the new manager was addressing this, and relatives had been invited to one on one meetings.

There was also a meeting for relatives' representatives the day before the inspection. During this meeting a number of concerns were raised by relatives and an action plan was put in place.
● Feedback had not been sought from health and social care professionals or staff. There were no records of regular staff meetings.'

The provider had failed to seek and act on feedback from relevant persons. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

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
● The registered manager had failed to meet the standards required under duty of candour. Following an incident on 24 November 2019 where one person received poor standards of care the registered manager had failed to investigate and failed to act in a transparent way.
● A complaint was received by the provider regarding this incident on 5 December 2019. The provider then undertook an investigation and issued a letter of apology to the persons relative on 17 January 2020.

Working in partnership with others
● At the time of the inspection staff worked in partnership with other agencies such as health and social care professionals where this was appropriate.
● However, there had been concerns throughout the previous year where concerns were not raised with the local authority.

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 18 Registration Regulations 2009 Notifications of other incidents
Treatment of disease, disorder or injury	The provider had failed to ensure that notifications were submitted to CQC when there was a notifiable event.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The provider had not ensured that support provided to people was person centred.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	The provider had not ensured that care was provided in a way that supported people's dignity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The provider had failed to ensure that care was provided in line with the Mental Capacity Action 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment

Treatment of disease, disorder or injury	The provider failed to ensure that risks to people were sufficiently monitored and that action was taken to reduce risks. The provider failed to ensure medicines were well managed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had failed to operate an effective accessible system for receiving, recording, handling and responding to complaints.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to assess, monitor and improve the quality and safety of the services. The provider had failed to maintain complete, accurate and contemporaneous records. The provider had failed to seek and act on feedback from relevant persons.

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 The provider had failed to ensure to maintain sufficient numbers of staff to meet people's needs. The provider had failed to ensure that staff had suitable training to enable them to carry out their role effectively.