Mr Pan Danquah & Mrs Kate Danquah

Dorcas House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Dorcas House is a 'care home' that is registered to provide personal care and accommodates up to 11 people living with dementia or mental health need in one adapted building. There were six people living at the home on the day of the inspection.

People's experience of using this service:
Since the last inspection in September 2019, improvements had not been made to address the areas we had identified as requiring action, and this inspection found further risks to people's safety were now present.

There was a continued failure to ensure all peoples risks were identified and managed well and this meant people were not safe and were at risk of avoidable harm. People's care plans lacked detail on their risks and the de-escalation techniques to be used when one person was distressed. Further guidance was also required on people's individual risks, including what the risk meant for the person concerned and information, so staff knew how and when to contact professional bodies for advice and guidance.

Staffing rotas show that the registered manager works seven days per week every week and the provider works six nights per week every week. This is not good practice and the provider confirmed there was no contingency plan was in place to ensure continuity of care to support people in the case of emergencies or annual leave.

Overall people were supported to receive their medicines as required however, improvement was required in the reviewing of PRN 'as required' medication. The general day to day practice supported infection control, but improvement was required to ensure all equipment is maintained cleanly to promote good infection control.

The provider's inadequate procedures and processes meant they had failed to ensure that people consented to their care. The Mental Capacity Act (MCA) includes how people are given choices about their care and how they want it delivered. Care records for one person showed they were not allowed out when it was dark, with no record of why this restriction was in place. The provider also had a generic smoking risk assessment and a generic wheelchair risk assessment for all people living at the home, that did not take account of people's individual capacity, individual risks or consent. The registered manager had a limited understanding of the principles of the MCA and would benefit from additional training.

Staff said training was appropriate to them in their role in supporting people's daily care. At the last inspection (September 2019) the provider told us training was up-to-date with the exception of two staff which was being addressed. At this inspection we found the training had still not been completed for one member of staff.

Staff liaised with other health care professionals to meet people's health needs and support their wellbeing. However, at the time of the inspection there was no process in place to record future medical appointments.

Required environmental improvements to the design and decoration of the home to support people's individual needs had not been completed therefore risks to people's safety remained.

People gave positive feedback about the choice of food provided. However, we saw one person at risk of choking was not supported with the correct diet to keep them safe. This meant the person was at immediate and ongoing risk of harm to their health, safety and wellbeing.

There was limited opportunity for some people to enjoy activities to avoid social isolation. There was no evidence that activities had developed with people's past interests and hobbies in mind. People we spoke with told us they were bored because there was a lack of activities.

The service has been rated as requires improvement in the key question 'well led' since February 2017 (and inadequate from November 2018). This inspection found the required improvements had not been made and further areas requiring improvement were identified.

The processes in place to monitor, audit and assess the quality of the service being delivered were not effective. The provider had a long history of not being able to improve the quality of the service provided to people or meet legal requirements. Provider audits not been effective in effecting sustained improvement and had not identified some the concerns we raised at this inspection.

At the last inspection (September 2019) we reported, "The provider was unable to demonstrate the systems they had in place to enable them keep themselves up to date with good practice or legal requirements." At this inspection we found neither the registered manager or the provider had received any further training or taken any action to keep themselves up to date with good practice or legal requirements.

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

Rating at last inspection:
The last rating for this service was requires improvement (published November 2019) and there were multiple breaches of regulation. Following the inspection, the condition on the provider registration requiring a monthly update remained in place.

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

Enforcement
Since the inspection in November 2017 there has been a condition placed on the providers registration. These conditions instructed the provider to send us regular updates on checks that had been carried out at the service to ensure the quality and safety of the service. The provider has submitted updates as per the conditions in place, however the quality of the submissions is not robust, and this has been discussed and shared with the provider.

This inspection found the provider remains in breach of regulation 12 safe care and treatment, this meant we found a failure to ensure all peoples risks were identified and managed well. We also found a breach of regulation 11, consent because people had not consented to some aspects of their care and regulation 9, person centred care. There was also a continued breach of regulation 17, this means insufficient action had been taken to make or sustain improvements in the service provided.

Please see the action we have told the provider to take at the end of this report.

Follow up:
We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The 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.

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 effective.

Details are in our effective findings below.

Inadequate

Is the service caring?

The service was not caring.

Details are in our caring findings below.

Inadequate

Is the service responsive?

The service was not 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

Dorcas House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team
The inspection team consisted of one inspector and an inspection manager.

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced and took place on 16 January 2020.

What we did:
We looked at information we held about the service, including notifications they had made to us about important events. We also reviewed all other information sent to us from other stakeholders, for example, the local authority and members of the public.

During the inspection, we spoke with three people using the service to ask about their experience of care. 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 spoke with the provider, the registered manager and one member of care staff. We also spoke to one

healthcare professional who was visiting the home on the day of the inspection.

We reviewed a range of records. This included three people's care records and a variety of records relating to the management of the service, including policies and procedures. Details are in the Key Questions below.

After the inspection
We continued to seek clarification from the provider to validate evidence found and actions taken following the inspection.

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 the provider systems had failed to ensure all peoples risks were identified and managed well. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This inspection found further improvement was required and the service remains in breach of regulations.

At the last inspection this key question was rated as requires improvement. At this inspection we found further risks to people's safety and this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management:

● The provider had failed to adequately assess and mitigate against the risks of harm to service users. For example, we saw one person had a SALT (Speech and Language) letter on file stating due to choking risks they should be provided with a pureed diet. However, the person's care plan stated they should be supported with a food that is 'mashed with a fork,' and 'A staff member to be present in the dining room at meal times for a quicker response should he choke.' We observed the lunchtime meal and saw that the person was provided with a meal that was not pureed and there were two short periods of time when no staff were present in the dining room. This meant the person was at immediate and ongoing risk of harm to their health, safety and wellbeing as the SALT instruction had not been followed and the person was at immediate risk of choking. When we asked the registered manager about this they advised they had made the change to a fork mash-able diet because the person did not like pureed food. The registered manager confirmed they had not sought advice or agreement from SALT when making this change. Immediate assurances were sought from the provider that a pureed diet would be put in place and a new referral made to the SALT team. The inspector also raised a safeguarding alert to the local authority.

● People's care plans did not accurately reflect current risks and give accurate guidance to staff to ensure people were supported safely. We saw that the care plan for one person stated they had poor mobility and must be supported by staff using a wheelchair. The care plan gave staff no guidance on the safe use of the wheelchair. We found a separate risk assessment for the use of wheelchairs for all people living at the home that stated, "Provided service users are strapped in wheelchairs and footplates are in place, the risk of an accident is less likely to happen." There was no personalised risk assessment for the person recording why a lap strap was required or guidance to staff on the safe usage of a lap strap. When we spoke to the provider we were told the lap strap was not used. When we inspected the wheelchair in use a lap strap was fitted to the wheelchair, although no footplates were present.

● The care plan for one person stated they required the support of two staff when mobilising. The care plan stated, "[Person's name] requires two people [staff] to support him onto his feet from the bed and armchair – using his Zimmer frame." Staffing rota's show there is only one member of staff on duty each night. When we asked the provider how the person was supported safely and in line with the risk assessment we were told only one member of staff was required and the plan had not been updated to reflect this. However, no assessment had been completed or rationale recorded for why this person's needs had changed to result in

less staff being required to support them safely. The inspection also found the bedroom of person contained trip hazards for example, a vacuum cleaner with trailing hose that is particularly hazardous for people with limited mobility.

● The inspection found that a second bed had been placed in one person's bedroom. The provider told us this was because the person was at risk of falling and the bed was used to prevent them from getting out of bed. There was no record of a risk assessment for this practice, or consideration that if the person climbed over the second bed this would present a greater risk of falls, and no record of discussion or consent from the person. This was not a safe strategy to support this person. Following us identifying this and raising it with the provider they took immediate action during the inspection to remove the second bed.

● Risk assessments were not in place to guide staff how to mitigate the risk to people from the environment. The inspection found there was open access to the rear of the adjoining property. The area contained unused equipment from the service such as work tools, a mattress, wheelchairs and other items including two sacks of potatoes. There were no risk assessments in place to show what actions were needed to keep people safe from accessing this equipment and to ensure items stored there were not accessible to people, and that food supplies were stored safely and could not be contaminated by rodents. Following the inspection, the provider told us the two sacks of potatoes were for the use of the two residents of No 54.

● At the last inspection (September 2019) we found there were no detailed plans in place that gave staff detailed strategies to support one person or personalised de-escalation techniques to be used when the person demonstrated distressed behaviour. At this inspection we found that the care plan had not been updated as required to provide guidance on how to support the person in order to avoid and minimize distressed behaviour. The provider said the care plan had been updated but acknowledged a copy was not on file and was not available at the inspection.

● At the last inspection (September 2019) we found that there were no detailed risk assessments for one person based on their past history and the care plan lacked detail on the risk management strategies. For example, there was no information on what the risk meant for the person and the care plan did not include information on the professional body to be contacted for advice and guidance. At this inspection we found that the care plan had not been updated as required to provide this information. The provider said the care plan had been updated but acknowledged a copy was not on file and was not available at the inspection.

A failure to ensure all peoples risks were identified and managed well is a breach of Regulation 12(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 Safe care and treatment.

Systems and processes to safeguard people from the risk of abuse

● Since the last inspection the provider had recorded one incident where people had been placed at risk. The incident had been identified as safeguarding concern by the management team and appropriate actions to alert the Local Authority and notify CQC had been made.

● We spoke to one member of staff who had received training in how to recognise possible abuse and was able to explain the actions they would take in response.

Learning lessons when things go wrong:

● Incidents records were completed to record any concerns; an audit was also completed which looked at the number of incidents over a period of time.

Staffing and recruitment:

● Staffing rotas showed that the registered manager worked seven days per week every week and the provider worked six nights per week every week. This is not good practice and we asked if a contingency plan was in place to ensure continuity of care to support people in the case of emergencies or annual leave. The provider said they did not take any annual leave and confirmed there was no contingency plan in place.

● At the last inspection (September 2019) we found the provider recruitment processes required improvement as the provider had not followed up gaps in one person's employment history and had not validated references to ensure they were credible. Since the inspection no new staff had been appointed but the provider confirmed the gaps in employment record identified at the last inspection had been addressed retrospectively.

Using medicines safely:
● We saw records that in November 2019 the provider had a CCG (Clinical Commissioning Group) medication audit. The audit found most areas of medication management to be in order but did recommended that a monthly review of PRN (as required medication) protocols should be put in place. We saw the provider had put record sheets in place but had not reviewed all of the PRN protocols as recommended by the CCG audit.

Preventing and controlling infection:
● At the last inspection (September 2019) we found people were not adequate protected from the risk of cross infection because we found there was a dirty radiator in one bathroom, some domestic equipment was being stored in another bathroom and the hand sanitiser dispenser in the reception area was empty. At this inspection we found people were still at risk. We found the dirty radiator in one bathroom remained and as there was no toilet roll holder in place, toilet rolls were placed on top of the dirty radiator. In the same bathroom we also found there were no paper towels available. In a second bathroom we found some domestic equipment was still being stored.
● Dorcas House was awarded a Food Hygiene Rating of 5 (Very Good) by Birmingham City Council on 17 October 2019.

Inadequate

Is the service effective?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection we found the provider's lack of procedures and processes meant they failed to ensure that people consented to their care and this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Ensuring consent to care and treatment in line with law and guidance; Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
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 as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.
People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

- We checked whether the service was working within the principles of the MCA. We found the provider had failed to ensure that people consented to their care.
- We found that the provider was unnecessarily restricting someone's movements against their will. The care plan in place for one person stated, "[Person's name] has said to the effect that if this is not a prison why can't I go for a drink? Obviously, he has capacity and conscious of his human rights. Staff to explain that he can go out in the day time and NOT when it is dark and night time." Records contained no risk assessment or capacity assessment to evidence this decision. We saw an incident dated 20 December 2019, recording when staff had refused for the person to leave the home. A second person also told us they couldn't go out at night. When we asked why this was, they told us, "Just the rules." The provider response when asked about this was that it was a duty of care to keep people safe; they demonstrated no recognition or understanding of people's rights to make their own decisions, and where people lacked capacity to make decisions those made should be in their best interests and as least restrictive as possible.
- We saw a risk assessment for smoking covering all people living at the home stated, "Service users who smoke never to be allowed matches/lighters." This was a generic risk assessment for all people and did not take account of people's individual capacity, individual risks or consent. We spoke to one person who told us they were not allowed to have their own cigarettes or lighter therefore each time they wanted to smoke they had to ask staff and they did not agree to this but had been made to hand over their cigarettes and lighter.
- At the last inspection (September 2019) we reported, "The Mental Capacity Act (MCA) includes how people are given choices about their care and how they want it delivered. Improvements are required as some people told us they felt they were not always involved in making decisions about how their care was delivered. The registered manager had a limited understanding of the principles of the MCA and would

benefit from additional training." At this inspection we found the registered manager had not completed any further training and people continued to tell us they felt they were not always involved in making decisions about how their care was delivered. One person commented, "She (the registered manager) wants things done her way, there's no choice."

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 Consent.

Supporting people to eat and drink enough to maintain a balanced diet;
● We received positive feedback about the food, with people telling us they liked the meals provided.
● We observed one person chose to have a late breakfast. When they initially requested cereal, this was refused but was then agreed to when the person persisted with their choice.
● We observed a lunchtime meal and saw people had different meals. When one person made a meal choice they were told that choice was no longer available, and an alternative was offered. Portion sizes were good, and people looked to enjoy their food.
● Two people told us they were only able to have drinks when they were offered by staff. People were not able to make their own drinks. The provider told us all people were allowed to use the kitchen facilities but only one person chose to do so.

Adapting service, design, decoration to meet people's needs
● At the last inspection (September 2019) we reported that environmental improvements were required. For example, only one light bulb out of five was working in the light fitting in the communal lounge. Radiator covers were not fixed and came away from the wall if lent on and the garden was overgrown and contained numerous broken plant pots.
● At this inspection we found not all environmental improvements had been completed therefore risks to people's safety remained. For example, only two light bulbs out of five were now working in the light fitting in the communal lounge, this left the room dimly lit. We asked the registered manager about this and they said it was a problem with the electrics, but the electrician they used had not had opportunity to fix it. They had taken no remedial action to put other lighting, for example, lamps, into the room.
● We found one radiator cover remained loose and one electric heater in the main corridor posed a risk to people as it fell from the wall when touched.
● We found the garden contained disused furniture and there was open access to the rear of the adjoining property (54 Fountain Road). The area contained unused equipment from the service such as work tools, a mattress, wheelchairs and other items.
● At the last inspection (September 2019) the provider advised that there were plans in place to repaint whole home in December 2019. At this inspection we found that the required improvements had not been made. The provider acknowledged improvements were still required and said they were now planned for March 2020. However, the provider had no strategy for implementing these improvements and we could not be confident that they would take place.

Staff support: induction, training, skills and experience
● At the last inspection (September 2019) the provider told us training was up-to-date with the exception of two staff which was being addressed. At this inspection we found the training had still not been completed for one member of staff. For example, we found one member of staff had safeguarding training overdue from 18 August 2018.
● We spoke to one member of care staff who said training was appropriate to them in their role in supporting people's daily care.

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

● People were supported to access healthcare services. However, we found there was no clear system in place at the time of the inspection to record health appointments. For example, records for one person showed following a dental appointment in August 2019 they had a follow up appointment scheduled for March 2020. When we asked the registered manager about this they told us no other appointments had been made and advised us that a diary to record appointments had not been put in place yet since the new year.

● We spoke to one healthcare professional who advised staff encouraged the person to make healthy food choices to support their wellbeing.

Inadequate

Is the service caring?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection we found further improvement was still required and the key question has deteriorated to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

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

- People's rights to make decision and lead their care were not respected. People were unable to do things they enjoyed like go out or smoke, without the permission of staff.
- We spoke to three people about their experiences of living at Dorcas House. Whilst one person said they were happy living there, another person expressed concern that they had not been involved in planning their care or discussions on how they preferred their care delivered. They told us they were unhappy living at the home.
- Some care plans included signatures of people's agreement when the care plan was first put in place, however there was no record of people being involved or consulted in subsequent reviews.

Respecting and promoting people's privacy, dignity and independence:

- One person told us they did not feel respected as they had been, "Undermined" when staff described them as, "The naughty one." Another person told us that staff sometimes shouted at them. We asked the registered manager about this, they advised this was not correct.
- People told us they were not always supported to maintain their independence. For example, one person told us they were not allowed to go out at night. When we asked why, they said, "Just the rules." Another person told us they were not allowed in the kitchen to make their own drinks therefore they had to rely on staff to make drinks for them.

Ensuring people are well treated and supported; equality and diversity

- We received mixed feedback from people about how they were treated. Whilst one person felt supported by staff, a second person felt they were not well treated by staff.
- We observed limited interaction between staff and people living at the home. Conversations were limited to what people wanted to eat and drink or people asking staff for a cigarette or a drink. We did not observe any meaningful interactions between staff and people.
- The inspection found one person was sleeping on a mattress that had a plastic cover on which would not promote comfort or good skin integrity. We also saw that bed linen and pillows were of a poor quality which would not promote comfort. The provider took action to change these items during the inspection. However, it is of concern that it took our prompting for action to be taken.
- Notes of a resident meeting in December 2019 recorded one person would like 'rice and peas.' Staff gave assurances this had been facilitated but we were unable to confirm this directly with the person on the day of our inspection.

● At the last inspection (September 2019) we noted a lack of pictures and images to reflect people's cultural heritage and discussed with the management team, that this was an area that could be improved to support people. At this inspection we noted that the required improvements had not been made.

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 requires improvement. At this inspection we found further improvement was still required and the key question has remained the same. This meant people's needs were not always met.

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.

- Two people told us they were bored because there was a lack of activities. One person told us how they, "Kill time watching TV in room [bedroom]." One visiting healthcare professional also told us they had not witnessed any meaningful activities for people when visiting the home.
- During the inspection we observed there was a lack of activities for people and people spent the day watching TV. When we asked one person if the TV programme showing was their choice, they said no, it was the registered manager who usually chose what was shown on TV.
- We observed there was limited opportunity for some people to enjoy activities to avoid social isolation and one person told us, "It would be nice if more [staff] so we could go out."
- The provider told us some people went out shopping during the day whilst two other people were not interested in doing anything except watching TV programmes.
- There was no evidence that activities had developed with people's past interests and hobbies in mind. For example, one person's care plan recorded they supported a local football team and liked to go matches. When we asked staff when they had last supported the person to attend a match they said it was some time (years) ago. We noted that this person's room had not been personalised in any way to reflect their hobbies and interests. When we later saw a picture of the football ground left on the side in the communal room we asked the provider about it. They said it was meant for the person's bedroom, but they had not had opportunity to hang it yet.
- Despite people expressing a preference to go out for activities in residents' meetings, many of the activities planned were games and activities with staff within the home. People we spoke to told us they did not always enjoy the activities and sometimes chose not to join in.
- The notes of a residents meeting in December 2019 recorded people's Christmas wishes. One person said they would like to go to the cinema, staff told us this trip had not yet been arranged at the time of the inspection.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

- We looked at the pre-admission assessment completed for a recent respite placement. The form was blank in many sections and did not capture the support needs and individual care required by the person in order that personalised care could be planned and provided.
- Care plans did not always contain detailed and personalised information to guide staff in providing care in the way people preferred. For example, we saw generic risk assessments for smoking and supporting people using a wheelchair. Care plans did not give staff guidance what this meant for the individual person concerned.

● Care plans in place were reviewed, and information was shared in the staff handover, so staff were aware of any changes in people's wellbeing.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 Person centred care.

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.
● We saw some information was provided in accessible formats. For example, the activities board was provided in a pictorial format. However, all other information was provided in written format. The registered manager told us this met the needs of the current residents and would be reviewed if people's needs changed.
● The information board in reception needed reviewing to ensure to showed current information. For example, we saw that a CQC poster from the last inspection (September 2019) was still showing. We also noted the menu board was also showing the menu for 10 January 2020 when we arrived, although this was subsequently updated by the registered manager.

Improving care quality in response to complaints or concerns:
● We received a mixed response from people about whether complaints were listened to. Whilst one person told us overall, they were satisfied living at the home; a second person told us they were unhappy and felt their concerns had not been listened to. We spoke to the manager about this and they advised us that the person's relative had agreed to the care provided. However, there was no evidence that person's relative had any legal authority to be making decisions on their behalf.
● The service had not received a formal complaint for over 12 months. We saw when one previous complaint had been received it has been addressed promptly and a record had been maintained.

End of life care and support.
● At the time of the inspection no one was being supported with end of life care. We looked at care plans showing people's future wishes. Care plans could be improved to include more detail to ensure people's wishes were recorded and known the staff supporting them.

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 the provider systems had failed to identify some of the areas for improvement and the provider had shown they were unable to sustain any improvements made. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This inspection found further improvement was required and the service remains in breach of regulations.

At the last inspection this key question was rated as inadequate. At this inspection this key question remains as 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.

Continuous learning and improving care

- The providers failure to have effective strategies to monitor and improve people's care had resulted in people being exposed to the risk of harm and people's experience of receiving care was not considered. The provider had placed restrictions upon people's liberty and failed to act upon their feedback.
- The service has been rated as requires improvement in the key question 'well led' since February 2017 (and inadequate from November 2018). This inspection found the required improvements had not been made and further areas requiring improvement were identified.
- The processes in place to monitor, audit and assess the quality of the service being delivered were not effective. The provider had a long history of not being able to improve the quality of the service provided to people or meet legal requirements. The provider had also failed to act upon of feedback and findings from previous inspections.
- Provider audits not been effective in achieving sustained improvements and had not identified some the concerns we raised at this inspection.
- Provider audits had failed to identify that processes and policies did not adequately assess and mitigate against the risks of harm to people and that that people's care plans did not accurately people's current risk and give accurate guidance to staff to ensure people were supported safely.
- Provider audits had failed to ensure that people consented to their care.
- The providers poor oversight failed to identify and address environmental concerns and had failed to identify staffing concerns with both the provider and registered manager six and seven days per week every week. The provider did not have a contingency plan in place to cover for emergencies such as illness.
- The providers poor oversight of staff training had failed to identify that people continued to be supported by staff who had not received up-to-date training to provide the skills required to support people safely.
- The providers had failed to identify that people did not have access to meaningful activities which reflect their interests and hobbies.

At this inspection we found sufficient action had not been taken to make or sustain improvements and the provider remained in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 Good Governance.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility

● The provider and registered manager had not consistently ensured people received person-centred care which meant that people were not always given choice to ensure they received care and support in their preferred way.

● Staff told us they felt listened to and that management team were approachable and supportive.

Working in partnership with others

● Records showed how the service worked with healthcare professionals in support of people's wellbeing,

● At the last inspection (September 2019), we saw no links to the immediate and local community had been developed or maintained and this was an area that needed improvement.

At this inspection we found the required improvements had not been made and community links had still not been developed.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The provider held residents' meeting to involve people in the service provided. We found that although action had been taken to address some issues raised this was inconsistent and some issues had not been addressed.

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

● At the last inspection (September 2019) we reported, "The provider was unable to demonstrate the systems they had in place to enable them keep themselves up to date with good practice or legal requirements." At this inspection we found neither the registered manager or the provider had received any further training or taken any action to keep themselves up to date with good practice or legal requirements.

● Staff told us they were supported to understand their roles through regular supervision meetings.

● The CQC inspection report rating was on display in the reception of the home. The display of the rating is a legal requirement, to inform people, those seeking information about the service and visitors of our judgments.

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 9 HSCA RA Regulations 2014 Person-centred care People were not being provided with person centred care.

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 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure that people consented to their care.

The enforcement action we took:

We issued a notice of decision to cancel the providers registration.

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 ensure all people's risks were identified and managed well.

The enforcement action we took:

We issued a notice of decision to cancel the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Sufficient action had not been taken to make or sustain improvements to the quality of care provided.

The enforcement action we took:

We issued a notice of decision to cancel the providers registration.