Four Seasons (No 10) Limited

Summerdale Court Care Home

Inspection report

73 Butchers Road
London
E16 1PH

Tel: 02075402200
Website: www.fshc.co.uk

Date of inspection visit:
25 June 2019

Date of publication:
29 July 2019

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Summerdale Court Care Home is a care home with nursing. It is registered to provide care and support to up to 110 people in one purpose built building. However, the provider had closed two of the units and limited their capacity to 58. There was one residential unit which specialised in supporting people living with dementia. There was one nursing unit which provided care to people with nursing care needs. Both of the units were on the ground floor.

People's experience of using this service and what we found
People told us they felt secure and that staff knew how to keep them safe. Allegations of abuse were appropriately escalated to the local authority to investigate. However, records and risk assessments were not always clear, and staff relied on their knowledge of people to keep them safe. People had not always been supported to take their medicines as they were prescribed.

Peoples views and opinions about their care needs and preferences were not consistently captured. People's goals had not been updated since they were written. People told us they liked the food, but there was very limited information about their preferences. Information about people's healthcare needs was not always clear or up to date.

Staff spoke about people in a derogatory way and offered very limited opportunities for people to have meaningful engagement. People's religious beliefs were captured, but there was no information about what this meant for their care preferences. We saw people's dignity was not always protected and staff did not take action to support people to preserve this.

People were supported by dedicated activities staff to attend a range of activities, including ones where external agencies and groups visited the home. However, the previous atmosphere of engagement with all care workers taking opportunities to provide stimulation to people had not been sustained. People had extremely limited opportunities for engagement or interaction with staff. Although people told us they found staff to be kind, they also told us staff were often busy. Care plans were reviewed each month but there was no evidence people were involved in this process. People and relatives told us they could make complaints to the manager.

The governance arrangements had failed to sustain and build on the improvements identified in May 2018. The quality assurance systems had not prevented a deterioration in the quality and safety of the service. The manager told us there was a problematic culture at the service but the provider had known this for a long time and effective action had not taken place to address this. The audit systems had repeatedly identified multiple shortfalls in the quality and safety of the service but the actions in place were not specific and would not improve the quality of life for people living in the home.

People were not always supported to have maximum choice and control of their lives. Staff supported them

in the least restrictive way possible and in their best interests. However, the policies and systems in the service did not support this practice. People told us staff asked for their consent.

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

Rating at last inspection and update
The last rating for this service was Requires Improvement (published 9 July 2018) and there were multiple breaches of regulations. At this inspection improvements had not been sustained and the provider was still in breach of regulations.

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

Enforcement
We have identified breaches in relation to risk assessments and medicines management, person centred care, dignity and respect, staff training and good governance.

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.

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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Summerdale Court 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
The inspection was carried out by two inspectors, two assistant inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Summerdale Court Care Home 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 did not have a manager registered with the Care Quality Commission. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager from the last inspection had left. There had been another registered manager since that inspection but they were no longer working at the service. A Resident Experience Manager was providing management to the home and was in the process of applying to become the registered manager.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
Before the inspection we reviewed the information we already held about the service in terms of notifications submitted to us. Notifications are information about events that providers are required by law to tell us about. We sought feedback from the local authority. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection-
During the inspection we spoke with 13 people who lived in the home and two relatives. We spoke with 10 staff including the regional director, two resident experience mangers (one of whom was managing the home), the deputy manager, two nurses, the chef and four care workers.

We reviewed the care files for seven people who lived in the home including needs assessments, care plans, records of care and reviews. We reviewed medicines records for both units. We reviewed six staff files including recruitment and supervision records as well as the training records for all staff. We reviewed incident and accident and safeguarding records, health and safety checks and various other documents, records and meeting minutes relevant to the management of the service.

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.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, staffing needs and deployment data, and quality assurance records.

Requires Improvement

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 Requires Improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

● The improvements to risk assessment and safety monitoring found in May 2018 had not been sustained. Risk assessments lacked detail and there were inconsistencies that meant people were at risk of harm.

● One person's risk of choking had changed recently. However, the information in their bedroom file had not been updated to reflect they now needed to have their food in a different consistency.

● People had personal emergency evacuation plans in place. However, these did not clearly explain how to support people to evacuate in an emergency. They said people needed assistance but did not explain what this meant.

● Risks associated with people's skin and developing pressure wounds were not always clear and consistent. One person's file contained conflicting information about how often they needed to be repositioned and their records from the day of the inspection showed they had not been supported to move for four hours when they should have been supported to move every three hours. Staff recorded the mattress setting for this person each day. The setting had changed mid-month but there was no explanation for this within the file. It was not clear if the person was on the correct setting for their mattress. The lack of clear information about their mattress settings meant there was a risk they were not on the correct setting for their risks.

● Some people living in the home could behave in ways that put themselves or others at risk of harm. The level of detail about how to support these people was not enough to ensure they were supported safely. One person's plan stated staff needed to be "very careful" when approaching them but did not describe how to support them if they were distressed. This person was prescribed medicine for "agitation" but there was no description of how to identify when they were agitated or what other measures to try before giving them medication. Staff spoke about this person's behaviours but did not describe how to divert their attention or how to support them to calm down.

Using medicines safely

● The improvements to medicines the provider had made at the last inspection had not been sustained and medicines were no longer managed safely.

● We found a medicines error that had not been identified by either of the nurses who had administered medicines to the person since the error had occurred. A person had not received the medicines they needed to control their diabetes. We also found a medicines recording error which had not been identified by the provider's systems.

● Staff were not following the provider's policy and procedure in relation to record keeping and stock balances. Records were unclear and showed people had run out of medicines with no action taken to ensure they had medicines in stock in a timely manner. People had run out of pain relief and constipation

relief medicines which meant there was a risk they were experiencing pain, or discomfort from being without their medicines.
● Information about when to support people to take medicines on an 'as needed' basis was not clear or specific, and in some cases did not exist at all. One person was prescribed different medicines of different strengths for pain. The guidance for staff said one medicine was for pain, and the other for "acute pain" but did not include any information about how to distinguish between types of pain. Other people were prescribed different types of laxatives but there was no guidance about the order in which to use them, or how long between bowel movements to administer the medicines. This meant there was a risk people were not supported with the right medication at the correct time to manage their symptoms.
● Information about people's medicines had not been kept up to date. One person had been prescribed medicines to be used if needed for pain relief. These were not on their medicine administration record (MAR). When asked why a nurse said, "We don't use them. The family don't want us to give them." This information was not recorded in the person's care plan.

The above issues with the quality of risk assessments and the safety of medicines management are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● At the last inspection in May 2019 we had identified a breach of Regulation 19 as the provider had not followed safe recruitment practices. This issue had been addressed and records showed recruitment had been conducted in line with the requirements to ensure staff were suitable to work in a care setting.
● People told us they did not think there were enough staff. One person said, "There needs to be more staff." Another person said, "The staff don't really have time to come and chat. They always walk with a purpose. If the staff weren't so busy here I would be happier." A third person said, "I don't think there are enough staff."
● Some staff also told us they didn't feel there were enough staff, although they recognised the current staffing levels matched with those calculated as needed by the provider's dependency tool. One member of staff said, "At the moment the dependency tool says we have the right amount of staff. In the morning it can be quite hard." Another staff member said, "There are not enough staff. We are doing our best. We are really busy all of the time." A third member of staff said, "We are very busy and occupied at the moment."
● The provider reviewed people's levels of need and dependency each month and this was used to calculate the numbers of staff needed. The provider told us the home had previously been over-staffed and this was why staff perceived the current staffing levels as insufficient.
● At the last inspection we observed that staff other than care assistants would engage with people, and provide additional support to care assistants, particularly at mealtimes. This was not the case at this inspection and we saw much of the care delivery, particularly at mealtimes, was task focussed and only provided by care assistants.

Systems and processes to safeguard people from the risk of abuse
● People told us they felt safe, though most people framed their sense of safety in terms of security. One person said, "I feel secure. I am kept clean." Another person said, "I am secure. The staff are fine." A third person said, "Yes, I feel fairly safe."
● Staff knew how to report and escalate concerns that people may have been abused. Records were well maintained and we saw allegations of abuse were raised with the local authority in a timely way.
● However, the local safeguarding authority told us they did not always receive the information they required in a timely way.

Learning lessons when things go wrong
● Records showed staff kept records of incidents and accidents within the home. Audits had identified

issues were not consistently captured in the early part of 2019 but this had been addressed by the time of our inspection.

● The home manager reviewed all the records regarding incidents and accidents. They had direct oversight of all actions in relation to incidents and accidents. This included communication with people's family members and other professionals where necessary.

● Records showed staff took appropriate action to ensure people's safety and wellbeing in response to incidents and accidents. For example, if someone had unexplained weight-loss appropriate referrals to healthcare professionals were made to explore any possible medical causes.

Preventing and controlling infection

● The home was mostly clean and free from malodour. We noted a smell of urine in and outside two bedrooms. We told staff about this who took action to resolve the issue.

● We saw domestic staff cleaning the home throughout the day using dedicated equipment and following good practice in terms of infection control measures.

● We saw personal protective equipment was in use and easily available for staff.

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 requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- The format of care files meant that historic information was more prominent than up to date information. This meant there was a risk that people did not receive the right support as it was not always easy to find.
- Although people's needs were described, their desired outcomes of care were not captured, nor were their preferences consistently or clearly recorded. This meant people, particularly those who could not easily express themselves, were at risk of not receiving care in line with their needs and preferences. Staff relied on people telling them things to fill in the gaps in the record and not all people could communicate this information clearly.
- People were unable to tell us if they were involved in planning their care or directing their support. Although they told us they were confident staff knew their needs well enough to support them. One person said, "They do understand my needs." Another person said, "They understand how to help me."
- The provider's assessment process involved using a range of standardised tools to assess people's needs and plan their care. The previous improvements in ensuring care plans were detailed and personalised had not been sustained. For example, one person's expected outcome was, "One female carer to assist with all aspect of personal care, [to] promote self-respect [and] prevent self-neglect." Another person was to be "supported and encouraged to meet all aspects of her personal hygiene need" The rest of the documents provided no further details to describe assistance or what people's choices were in relation to these areas of care.
- Information in care plans did not always match our observations of care. For example one person's care plan described how they should be served their meal. We saw this person was much more engaged and was involved in laying the table for others in the unit. As this information was not included in the care plan there was a risk that not all staff would know that she liked to be involved in this way.
- Other care plans contained insufficient information to ensure people's needs and choices were met. For example, one care plan stated the person "Needs the assistance of one or two staff depending on her mood." There was no detail to help staff identify her mood, or what assistance meant.

The above issues are a breach of Regulation 9(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- At the last inspection we found a breach of Regulation 18 as staff had not received the training and support they needed to perform their roles. While there had been some improvements, concerns remained.
- Although the number of staff who had completed the required training had improved, there were gaps in

staff training that put people at risk. Training records showed neither of the nurses on duty on the day of the inspection had completed all the medicines training courses required by the provider. Both nurses training on anaphylaxis had expired. This meant there was a risk that no one on duty had appropriate training to respond to a severe allergic reaction.

● People told us they thought staff knew how to do their jobs. One person said, "I think that they [staff] are well trained." Staff told us they completed online training courses.

● Supervision records had improved and staff told us they found supervisions useful.

● The local authority had identified gaps in recording of inductions on their monitoring visits. This issue had been addressed by the time of our inspection.

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

● People's feedback about the food varied. One person told us, "The food makes me happy." While another person said, "The food is OK." Another person said, "We get options for food. The food is alright. I used to be very fussy."

● In May 2018 we noted the information in the diet notification sheets was brief. There had been no improvement in the level of detail, and preferences were limited to types of cuisine and breakfast choices. For example, several people liked "English food" and another liked "rice and curries." The chef confirmed she sought more detail from people on an individual basis but as this information was not recorded there was a risk it would not be maintained if the chef was unavailable.

● We observed lunch in both units during the inspection and found the mealtime experience was task focussed and silent. Staff focused on ensuring people were given their meals, and there was no conversation taking place. In one unit three people moved into the dining room 30 minutes before their meal was served. No one talked to them or interacted with them apart from to serve their meals. In the other unit people also waited about half an hour in silence for their meals. Staff appeared to be rushing to ensure people received their meals and did not ask if people were enjoying their food or have any conversation at all.

● At previous inspections domestic staff had been involved in ensuring the mealtime experience was a positive time, which included social interaction. During this inspection domestic staff were not involved in meal time support.

● Records of people's nutritional intake were poor. One person's records showed they had eaten "puree" for a week, with no detail about what this puree had consisted of. Their fluid intake had not been totalled for the entire week. Apart from one day when no fluid intake was recorded, their records showed they consumed between 700 and 1250ml fluid a day. However, as there was no guidance about how much they should aim to consume this did not mean anything and it was not possible to tell if this was sufficient for them.

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

● The progress identified in May 2018 regarding recording people's healthcare needs and records had not been sustained.

● Staff recorded updates from healthcare professionals in the healthcare professional visits log section of files. Some professionals had written their instructions in other sections as well to ensure they were shared with staff. For example, we saw a doctor had written detailed instructions for how to manage one person's diabetes care in three different places within the file.

● The home had changed their GP and staff reported they received better support from the new surgery. However, some people's health information, including medicines administration records, had not been updated and still referred to the old GP. This meant there was a risk that the wrong people would be contacted for support with medical issues.

● People had hospital passports in their files. These had not been well completed; one had not been

reviewed or updated since 2017 despite significant changes in the person's health. Another was blank.
● Staff told us the GP visited the home once a week and that the deputy manager coordinated the list of people who needed to see the GP. This system was not working effectively as we found people who had run out of medicines and had not been supported to see a doctor. The nurse we spoke with told us they did not have any involvement with the process of arranging for people to see a doctor.

Adapting service, design, decoration to meet people's
● Summerdale court care home is a purpose-built care home. In response to previous reductions in the number of people receiving care, the provider had made the decision to close the two upstairs units and move everyone into the downstairs bedrooms.
● People's bedrooms has been personalised and we saw people had put up photographs and mementoes to remind them of their lives before moving into the home. Staff had completed personal profiles with important information about people which were displayed on bedroom doors.
● The home had adapted bathrooms and en suite facilities available for people which were suitable for people's needs.
● The manager's action plan included making improvement to the signage to make sure the building was more dementia friendly.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● Staff had made appropriate applications to the local authority for DoLS authorisations. There was a system in place to monitor DoLS and submit renewal applications when necessary.
● The progress noted at the last inspection in May 2018 regarding capacity assessments had not been sustained and we found records were unclear and confusing about people's capacity to consent to their care. For example, one person who was described throughout their care file as having full capacity to consent to all their care and treatment had a capacity assessment and best interests decision making record for living in a locked environment.
● Another person's capacity assessment and best interests records stated their family were involved with making complex decisions. However, other parts of their file stated their family were not involved and there were no contact details for any family members within the file. The person had a court appointed deputy to manage their finances.
● Despite these issues, care was generally being provided to people in a way that reflected the principles of the MCA as care was in people's best interests and staff respected people's expressed choices.
● One person said, "They always seek my consent."

Inadequate

Is the service caring?

Our findings

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

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

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

- Staff did not treat people with the dignity and respect they were entitled to. Their approach was dehumanising and demonstrated a lack of respect towards the people living in the home.
- Two nurses spoke about people who lived in the home only in terms of their behaviours. When describing one person to a member of the inspection team a nurse said, "Be careful if you go in there, [person] might throw their juice at you, throw their frame at you, or pinch your bum if you're lucky."
- One nurse, in conversation with the other nurse in front of the inspectors, was talking about how this person preferred to have their blood taken at the hospital. The nurse put on an accent and did a derogatory impression of the person asking to go to hospital.
- These issues were raised with the provider who assured us they would take action to address the concerns. The provider told us these staff members had not realised the way they spoke about people was derogatory and offensive.
- Information about the impact people's religious beliefs and cultural background had on their care preferences was limited. For example, one person's care file described them as being devout in their faith. There was no information about what that meant, and whether it affected how they wished to receive their care. There was no information about religious festivals or events and how the person wished to be supported to adhere to their faith. Another person's care file stated simply "Christian" in the section which was meant to describe their religious beliefs or culture and how they would like support to meet those needs. Staff told us about visiting faith representatives, but did not know how to support people to practice their faith outside of these visits.
- At the last inspection in May 2018 people's care files had contained detailed life story books with details about people's families, relationships and other significant events. The manager told us the manager who had been in post between our inspections had removed this section from the files and it was not possible to find it now. The activities staff had started to complete these files again. However, the quality and detail was not as much as had been in the files last time.
- In May 2018 we had observed positive, and compassionate interactions between people and staff. Staff of all grades across all the units had understood their role in engaging and interacting with people. This was no longer the case and people were not receiving the same levels of engagement and interaction from staff. We saw three people sat in a dining area for 30 minutes had no interactions until a senior manager spent less than a minute interacting through a window.
- We used SOFI to observe the nature of interactions between staff and people. We observed four people for twenty minutes. Only one person had positive interactions with staff. One person had some task-based interactions. Another person only had interactions because they needed to move position for another

person. The fourth person had no interactions throughout the observed period and continued to have no interactions for the next 15 minutes.

Respecting and promoting people's privacy, dignity and independence
● A member of the inspection team saw a person's clothing had slipped and their underwear was on show. The person was with staff who took no action to support them to rearrange their clothing to protect their dignity. Over the course of half an hour this person was left in an undignified state despite being supported by staff.

The above issues with staff attitude, interactions and a lack of dignity are a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Despite the issues outlined above, people told us they found the care staff kind. One person said, "They [staff] treat me with dignity." Another person told us, "They are good carers, not bad at all. They are still nice when my visitors go home which is impressive."
● However, other people told us there were inconsistencies in how staff treated them. One person said, "They always seem busy." A relative told us, "They are improving."

Supporting people to express their views and be involved in making decisions about their care
● People's views about their care were only captured in the original care plan, which was frequently historic. People's views were not clearly captured in the monthly reviews which were completed. These recorded whether people's needs had changed but did not capture what people thought about the care they had received.
● For example, one person's cognition care plan recorded their views regarding activities of daily living and familiarity with staff. The monthly reviews only recorded that the person "remains orientated to people time and place" and commented on their ability to recognise staff.

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 now deteriorated to 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; 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

● The service had not sustained the level of detail and personalisation found in care plans in May 2018. Where information had been removed from files and replaced, the level of detail and personalisation had deteriorated. Although care plans were reviewed each month, there was no evidence that people were involved in these reviews or invited to give their opinion on the care they received as part of these reviews. The provider told us people's feedback was captured as part of the quality assurance process through questionnaires.
● In May 2018 there had been significant improvements in the level of detail about people's relationships and how they should be supported to maintain them. People were encouraged to talk about their relationships, and sexual identity at residents meetings facilitated by the activities coordinator. However, the detail about people's relationships had been removed from care files, and while there was a programme ongoing to replace this, the level of detail had deteriorated. For example, one person's sexuality care plan simply stated, "She has children."
● In May 2018 we had seen people were being routinely engaged in a range of activities facilitated by both care workers and dedicated activities staff. This had not been sustained and activities had returned to being the sole responsibility of the activities staff. Care workers waited for activities staff to initiate all activities and opportunities for engagement. For example, people had gathered in the cinema room and were waiting for the film to start in silence. There were two care workers in the room, one of whom commented the film would be put on when one of the activities coordinators was available. People had to wait for a further twenty minutes for an activities coordinator to arrive and insert the DVD into the player.
● The activities staff had continued to support a full programme of structured activities, agreed through regular meetings with people. They facilitated external activities programmes including visits from a local nursery group and arranged outings. They also ensured that representatives of different faith groups attended the home.
● Outside of the structured activities sessions people had limited or no opportunities for engagement. One person's records showed they had asked to go for a walk. Staff had recorded, "[Person] said she wants to go out and I said she can go out with her family maybe tomorrow." Another person told us they used to visit their place of worship, but they were no longer able to do so as there was no one to support them to go.
● Another person's care records showed they did not like to attend the structured activities. However, there was no record to show any alternative attempts to engage and stimulate the person were offered.
● Staff told us the home had introduced "The Two O'Clock Stop" where all staff stopped what they were doing and spent ten minutes engaging with people. We saw that this took place, and domestic staff engaged

positively with people. We saw from the smiles and conversation generated that people responded to and valued these interactions. However, some care workers did not take part in this, and continued to write their log books during this time. The isolated nature of this positive interaction highlighted the lack of interactions throughout the rest of the day.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (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.

● Care plans were not in a format that was accessible to people who received care. In our last inspection report we highlighted that the format of care plans did not facilitate easy use by staff. There had been no progress on ensuring that care plans were more accessible to both people and the staff who used them.

● Each care file contained a section relating to people's communication needs. Likewise, each capacity assessment and best interests decision record included a section for staff to record what alternative communication methods had been attempted to support people to understand.

● The service was not consistently facilitating people's communication effectively. For example, one person spoke English as a second language. A nurse was asked about what opportunities this person was given to speak in their mother tongue. The nurse said, "There's [named staff member], it's not the same language but it can get through. There's a member of staff from the kitchen. [Person] can understand English, they say the odd word in English. Their actions show you, we can understand them. It's quite funny. It all depends on whether they like you or not. If they don't like you they'll throw you out of the room." This showed a lack of understanding of the importance and impact of being able to communicate easily in the language of people's choice.

Improving care quality in response to complaints or concerns

● People and relatives told us they would raise concerns or complaints with the manager. A relative told us they were confident the manager would address their concerns.

● Records showed complaints had been investigated and responded to in line with the provider's policy, with apologies offered where appropriate.

● People were given regular opportunities to raise complaints and concerns through residents' meetings and individual feedback questionnaires.

End of life care and support

● The level of detail about people's end of life care wishes varied. Some care plans contained details about how people wished to be cared for, and who they wished to be present. Other care plans lacked detail and simply advised that people wished to be supported to be pain free.

● Records showed staff liaised with healthcare services and the local palliative care team when they needed support to care for people in the last stages of their life.

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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

In May 2018 we had identified a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the governance arrangements in place were not effective. The provider had failed to address this issue and the breach remained.

- The provider's systems of audits and checks had not consistently identified or addressed issues with the quality and safety of the service. Issues that were identified as requiring improvement at the last inspection had not been addressed.
- The inspection in May 2018 identified that the format of care plans was not helpful to care workers and some care plans still required updating to make them personalised and accurate. There had been no changes to the format of care plans, and updates had not been completed. The manager told us, "We have been looking at the care plans. It is a work in progress. All of them need to be re-written from scratch." Despite this being a known issue, there was no clear action plan in place to ensure this happened. The provider had failed to learn from previous deteriorations in quality and safety of service.
- The provider's medicines audits had identified multiple issues with the quality of medicines records but had failed to take action to address these concerns. For example, the lack of detail in 'as needed' medicines instructions was noted in January 2019 but had not been addressed by the time of our inspection in June. Multiple medicines audits identified that there were no kits to respond to hypoglycaemic attacks. Multiple medicines audits identified that no action had been taken in response to a patient safety alert. The manager had recorded that the action to be taken in response to medicines audits findings was, "All staff that administer medications must adhere to company policy and ensure these items are addressed. [Deputy manager] to monitor." This was not sufficient to address the issues found during the inspection.
- As people and staff had told us they felt staff were sometimes rushed we asked for information about call bell monitoring. The provider told us they were unable to access information about how long it took for staff to respond to call bells.
- The manager had completed an analysis of the audits completed between March and May 2019. Although the analysis identified issues with the quality and reliability of the audits, the actions were vague and without timescales. For example, regarding the environment of the home one of the actions was "All staff to take pride in keeping the home neat tidy and arranged." The actions to address the governance shortfalls were not specific and delegated actions to other staff to raise in meetings, rather than being specific about who needed to do what to make improvements. The action to address a list of 53 issues identified with

resident care was, "CHAPS/Nursing staff to address all issues listed. Deputy manager to support."
● The manager told us audits had been destroyed and sections removed from care files since our last inspection. Despite the history of failing to meet the regulations and poor ratings, the provider had failed to prevent this from happening. The provider told us they had no evidence that audits had been destroyed and sections removed from files. However, we found sections of care plans were new, and of a lower quality, than they had been at our last inspection
● The manager was in the process of applying to become registered with CQC. On the day of the inspection the provider told us they had made an offer to another candidate to become the dedicated home manager.
● During the inspection we identified records for people were not well maintained or accurate and there had been a lack of oversight regarding records.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The manager told us at the start of the inspection that there was a problematic culture in the service. We had also received this feedback from the local authority. We had previously reported on problems with the staff culture in our inspection reports dating back to January 2016.
● The manager told us they occasionally felt that they were being bullied by the staff team. We had been told this by a previous registered manager and deputy manager so this issue had been known by the provider for a number of years. No effective action had been taken to address this.
● A member of staff told us there was a pattern within the home of allegations being made against staff. They said, "They [other staff] call us racist when we aren't friendly to them."
● Feedback about the current manager varied. One member of staff said, "They are marvellous. She is very inclusive." However, another member of staff said, "There's no problem solving with this manager. She tells you what she wants and you have to work around it. She's not very engaging."
● At previous inspections staff have spoken to us openly and candidly about issues within the home. However, at this inspection we found staff were reluctant to speak to us, and much of their feedback was framed as being only relevant for their own experience.
● The management systems had failed to identify or address the attitudes of nursing staff which led to them making derogatory comments about people to the inspection team.

The above issues with the quality assurance and governance systems, and the problematic culture in the home are a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 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
● Records showed the provider offered open apologies to people when things went wrong as part of their complaints process. When incidents occurred staff informed relatives where it was appropriate for them to do so.
● Provider are required by law to submit notifications about different types of event to CQC. The provider was informing us of events as required.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The activities staff facilitated regular residents' meetings where people were given the opportunity to be involved in the service. Records showed staff informed people of developments within the home such as changes in management.
● The audit systems had identified that staff and relatives' meetings had not been taking place regularly as

the provider required. The manager had scheduled meetings to ensure this started to happen again.
● There were i-pads available in the reception area for people, relatives and visitors to give their feedback about the home. The manager told us they found it challenging to respond to staff feedback as it was often anonymous.

Working in partnership with others
● The activities staff had continued their partnership working with local voluntary sector organisations, schools and religious groups. Through their involvement people were supported to maintain some links with their local community.
● The manager told us they felt their working relationships with healthcare services had improved. They were now working with a different GP practice which had involved a significant amount of handover and joint working to ensure continuity of care for the people living in the home.