HC-One Oval Limited

# Capwell Grange Care Home

## Inspection report

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Tel: 01582491874

Date of inspection visit:
03 April 2019
04 April 2019

Date of publication:
28 May 2019

## Ratings

| Overall rating for this service | Requires Improvement |
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| --- | --- |
| Is the service safe? | **Requires Improvement** |
| Is the service effective? | **Requires Improvement** |
| Is the service caring? | **Good** |
| Is the service responsive? | **Good** |
| Is the service well-led? | **Requires Improvement** |

# Summary of findings

## Overall summary

About the service:
Capwell Grange Care Home is a 'care home'. It provides personal and nursing care for up to 146 people living with a variety of health conditions, physical disability and dementia. The service also provides short-term care and treatment to adults who require a period of rehabilitation following a stay in hospital due to ill-health, surgery or an injury. The service comprises of five self-contained bungalows which they call 'houses'. At the time of the inspection, 115 people were being supported by the service.

People's experience of using this service:
People were not always protected from harm because potential risks to people's health and wellbeing were not consistently managed well. Some care records were not up to date, legible or accurate which meant staff could not always provide safe care. There were not always enough and consistent staff to ensure people's needs were met safely. People found the higher use of agency staff in recent months did not ensure they received consistent care. Incidents were not always reviewed in a timely way to enable learning from them and to reduce the risk of recurrence.

People's rights were not always protected. Restrictions on people's liberty had not always been authorised because most of the Deprivation of Liberty Safeguards (DoLS) authorisations had not been renewed. Applications had also not been made for people new to the service who may lack mental capacity to make decisions about their care. Formal support for staff by way of supervisions had not been regularly carried out.

The provider's quality monitoring processes had not been used effectively to drive continuous improvements. Inconsistent management and leadership of the service had resulted in declining in standards of care and safety. Audits had not been carried out regularly to ensure people received good quality care. There had not been opportunities for people to provide feedback about the service because meetings were no longer planned regularly. The above issues resulted in breaches of three regulations.

However, people, relatives and professionals told us staff provided care in a caring and responsive manner. Feedback from everyone was positive about how staff supported people in a kind and person-centred way. There was evidence that people mainly received good care because staff worked hard to support people the best way they could.

Staff supported people well. However, they found e-learning was not always effective at helping them to learn. The provider was going to look at further ways of supporting staff to develop their skills. People were supported well to have enough to eat and drink. Staff supported people to access healthcare services when required. People's medicines were managed well. This helped people to maintain their health and well-being.

People said they were involved in making decisions about their care and support. Staff respected and

promoted people's privacy, dignity and independence.

There was a system to ensure people's suggestions and complaints were recorded, investigated, and acted upon to reduce the risk of recurrence. However, more needed to be done to ensure there was a way of recording concerns raised by people or relatives in each of the 'houses'.

Rating at last inspection:
The service was rated 'good' when we last inspected it. That report was published in July 2018.

Why we inspected:
This inspection was prompted by information of concern that was shared with CQC. This showed people were at risk of potential harm because of poor care records, poor infection control measures and inadequate governance.

Enforcement: There were four breaches of regulations. We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety.

Follow up:
We will monitor the progress of the improvements working alongside the provider and local authority. We will return to visit as per our re-inspection programme. If any concerning information is received we may inspect sooner.

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

## The five questions we ask about services and what we found

We always ask the following five questions of services.

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|---|---|
| **Is the service safe?**<br>The service was not always safe.<br>Details are in our Safe findings below. | **Requires Improvement** |
| **Is the service effective?**<br>The service was not always effective.<br>Details are in our Effective findings below. | **Requires Improvement** |
| **Is the service caring?**<br>The service was caring.<br>Details are in our Caring findings below. | **Good** |
| **Is the service responsive?**<br>The service was responsive.<br>Details are in our Responsive findings below. | **Good** |
| **Is the service well-led?**<br>The service was not always well-led.<br>Details are in our Well-led findings below. | **Requires Improvement** |

# Capwell Grange 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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted by information shared with the Care Quality Commission (CQC) which showed people were at potential risk of harm due to poor infection control measures, insufficient staffing, poor staff training and support, incomplete or inadequate care records, accidents and incidents records not up to date, and poor quality monitoring processes. There were also four whistleblowing concerns about poor leadership and management of the service, and poor management of medicines. This inspection examined these risks.

Inspection team:
On the first day, the inspection team consisted of two inspectors, a nurse specialist advisor, a pharmacy advisor and two experts 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. Their area of expertise was in the care of older people and those living with dementia. One inspector visited the service on the second day.

Service and service type:
Capwell Grange Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. 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. There was a manager who had been at the service since November 2018, but they had not yet registered with CQC. 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.

Notice of inspection:

The inspection was unannounced.

Inspection activity started on 3 April 2019 and ended on 4 April 2019. We visited the service on both days to see the manager; speak with people using the service, relatives, care staff and visiting professionals; and to review records, and policies and procedures.

What we did:
Before the inspection, we looked at information we held about the service including notifications. A notification is information about events that registered persons are required to tell us about. We used this, and information shared with us by the local authority, local clinical commissioning group and whistle-blowers to plan the inspection.

During the inspection, we looked at various information including:
Care records for 14 people, and medicines records for 28 people.
Records of accidents and incidents; compliments and complaints; audits; surveys.
Three staff files to check the provider's staff recruitment processes. We also looked at supervision and training information for all staff employed by the service.
Some of the provider's policies and procedures.

We spoke with 23 people using the service, seven relatives, four activities coordinators, six nurses, nine care staff, the manager, and the provider's area director. We also spoke with three professionals who worked closely with the service to provide rehabilitation care and treatment.

Requires Improvement

# Is the service safe?

## Our findings

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

People were not safe and were at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management
● People had risk assessments to monitor risks in a range of areas such as mobility, nutrition, skin care, falling, use of bed rails, choking, and some related to specific health conditions and treatments. We saw the risk assessments were reviewed monthly.
● However, some of these records were not always up to date or accurate. For example, one person had two risk assessments relating to their treatment with a specific medicine. Both had different risk ratings which made it unclear what the level of risk was. This could confuse staff, resulting in unsafe care for the person.
● People assessed as being at risk of not drinking enough had charts to monitor how much they drank daily. We found staff were not using these effectively, as the charts were not always completed fully. The charts did not show what the expected levels of fluid were, were sometimes filled in when a drink was left next to the person, but not drank. There were no daily totals to show whether people were drinking enough. It was therefore, not clear how this information had an impact in monitoring how much people drank to maintain their health.
● Most of people's care records were handwritten and some of them were difficult to read. Some staff told us they sometimes struggled to read some of the handwritten records. We found this put people at risk of unsafe care. The area director told us the provider was considering introducing an electronic care planning system which will improve the legibility of the records. In the meantime, they were going to review all the records to ensure they were legible.
● Some of the people mainly cared for in bed did not have access to their call bells. There was no information to show they could not use these. This put them at risk of harm because they would not easily call staff if they needed help.

The inconsistent quality of care records and risk assessments put people at risk of unsafe care. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staffing and recruitment
● The provider had safe staff recruitment procedures to make sure staff employed by the service were suitable. The manager had completed all necessary checks, including with the Disclosure and Barring Service (DBS). These checks reduced the risk that potential new staff may be unsafe to work at the service.
● Information shared with CQC showed the service did not always have enough, skilled and consistent staff to support people safely and in a timely way. Staff told us there had been high use of agency staff at the service. Some staff said the agency staff were skilled and knew people using the service's needs and care plans. However, others said this was not always the case. Some staff said they sometimes found it difficult to work with agency staff as they did not always know how to support people.
● One staff member said, "We have had a lot of agency staff lately because some staff were taking their leave. It is not always easy to work with agency staff if they don't know the residents' needs. When we are

busy, we don't have time to show them what to do."
● Another staff member told us, "Staff are getting a bit fed up of it (use of agency staff). It's not fair on residents to see different faces all the time. We've told managers about it, but we are not sure if anything is being done to get more staff. We will see when it happens."
● People and relatives also told us there were staff shortages at times. One relative said, "Sometimes they are really short of staff, you see them rushing around with not a minute to spare." However, everyone told us staffing levels had got better in the week prior to the inspection because most staff were back from their leave. Some people said there were staff shortages particularly at night and at weekends. However, we did not see evidence of this in the rotas we looked at.
● Most people told us they were normally supported quickly by staff when they used their call bell. Others said staff were always busy and were sometimes not able to support them promptly. One person said, "They come and hold up 5 fingers to say 5 minutes, and then don't come back." Another person said, "I've waited more than 20 minutes. It's a long time when you want to maybe use the toilet."
● The manager and the area director acknowledged that there had been recent staffing challenges which they had been working towards solving. We saw they had recently recruited 11 new staff who were waiting for their pre-employment checks to be completed before starting work. This was a positive step towards ensuring people were supported safely and by a consistent team of staff.

Using medicines safely
● We received information that medicines were not always managed well at the service. This included concerns that a significant number of tablets had gone missing in one of the houses. The manager had not notified the local authority and CQC about this safeguarding incident, but it had been recorded in the provider's system for reporting incidents. They told us they had been advised by the provider's quality team that an internal investigation would take place first. This was still in progress at the time of the inspection.
● We reviewed how medicines were managed at the service and we found there were effective systems to manage medicines safely. The pharmacy advisor looked at the medicine administration records (MAR) for 28 people and found no concerns with how medicines were recorded, stored and given to people.
● People told us they were supported well by staff to take their medicines. They had no concerns with how staff managed this. One person said, "They do all my medicines. They order them, and they bring them round. It works good for me."

Learning lessons when things go wrong
● There were systems to ensure incidents or accidents involving people using the service, visitors and staff were recorded. However, staff told us incident reports were not always checked by the manager in a timely way to ensure they put safeguards in place to prevent the risk of recurrence.
● Staff told us because of this, they did not always know whether any action had been taken to improve. They said the lack of feedback about what had been done did not promote effective sharing of information and shared learning.
● We saw incident records that had no evidence that they had been reviewed by the manager. This did not promote learning from incidents, which was necessary to ensure the risk of them happening again had been reduced. This was part of wider concerns about the effectiveness of the provider's quality monitoring processes. Improvements were required.

Systems and processes to safeguard people from the risk of abuse
● People told us they felt safe living at the service. Everyone said staff supported them well and they had no concerns about potential abuse, neglect or unsafe care. On person said, "I feel safe here, I have a lot of people (staff) around to help me."
● Staff knew how to keep people safe because they had been trained on this. Staff knew how to identify

people at risk and appropriately report concerns. One staff member told us, "Residents are safe here. I would always report to the shift leader if I am worried about someone."
● Records showed the manager and other senior staff reported most potential safeguarding concerns to the local authority and CQC in a timely way.

Preventing and controlling infection
● We observed the service was clean and hygienic. One person said, "The cleaners are good, they are always popping in to make sure things are clean." One relative told us, "They seem to keep the place clean and tidy."
● Staff told us they had enough disposable gloves and aprons to use when required. We saw adequate stocks of gloves, aprons and disposable wipes were kept in each of the houses. This helped staff to protect people against acquired infections.
● Staff told us they were trained in infection prevention and control, and training records confirmed this.

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

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

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 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, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met. We found these were not met.
- Information shared with CQC showed expired DoLS authorisations had not been renewed. Also, no applications had been made for people who were new to the service and lacked mental capacity to make decisions about their care. The DoLS trackers on each of the houses had not been updated since November 2018. At the time of the inspection, the manager was systematically working on sending DoLS applications and this process had only been completed for people living in one of the five houses.
- Records showed some people had capacity to make decisions and had given consent to their care and support. Where necessary, relatives or professionals supported people who had no capacity to make decisions about their care. This ensured any care provided was in people's best interests. However, mental capacity assessment records were not always consistently completed fully to show whether people had capacity to make decisions about their care. This was part of wider improvements required in the quality of care records.
- However, no one had no concerns with how people's rights were promoted by care staff. This was because we observed, and people told us staff always asked for their consent before providing care and support.

The lack of robust processes to ensure any restrictions on people's liberty had been authorised meant people's rights were not fully upheld. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Adapting service, design, decoration to meet people's needs

● People told us staff provided good care to meet their individual care needs. One relative told us they were pleased their relative who fell frequently at a previous care home had not fallen here. They also said, "They use a hoist and they all seem to be competent. There are always two staff to move [person]."
● There were systems to assess people's care and support needs. People had care plans which showed how their needs, choices and preferences would be met by staff. However, the quality of the care records varied across all the houses. Some of these needed to be improved to ensure people consistently received effective care. We discussed this with the managers. They told us they would review all care records to ensure they accurately reflected people's current needs, were legible and staff could easily understand them.
● The design and decoration of the service was suitable to meet the needs of people living with a variety of needs, including those living with dementia. A relative of a person living with dementia told us, "My [person] likes to walk around, so they have given him a bedroom at the end of the corridor. He knows that is his bedroom when he reaches the end of the corridor." We saw 'memory boxes' placed on the walls outside people's bedrooms also helped them to remember which bedroom theirs was. We also saw that nurses made referrals to other professionals if equipment was required for people to receive safe and effective care.

Staff support: induction, training, skills and experience
● Staff were trained and supported to gain skills necessary for them to support people effectively. Staff training was now mainly delivered through an online system, with some practical training in areas such as, moving and handling, basic life support and fire safety. Some staff were not happy about this change, as they said it was not the most effective way of providing training. One staff member said, "I don't like the online training. Some of the staff who are not computer literate struggle with this. I prefer face to face training as I learn better when I'm shown what to do. It helps to talk to others about what you are learning too, you remember it more." Managers told us they would look into assessing staff competence more often to ensure training was effective.
● One staff member who had completed an induction in recent months found this effective. They said, "I did face to face training and then shadowed shifts. I wasn't thrown in at the deep end, I always worked with someone until I was competent. It was also helpful to find out about HC One and how they work."
● Staff told us they felt supported in their work, but some of them said they had not had recent supervisions. Records showed some of the staff's supervisions were out of date across the service. The house managers showed us they had plans to update this as soon as possible. This meant there was no evidence that staff were formally supported regularly and that their performance and competence were reviewed frequently. This could lead to poor care if staff's skills deficits were not identified and rectified quickly.

Supporting people to eat and drink enough to maintain a balanced diet
● People told us they had enough to eat and drink, and they enjoyed their food. Records showed that overall, people were supported well by staff with their food and drinks as most people had either maintained or gained weight.
● However, staff and relatives told us there was not much choice for people who ate pureed food. One relative said, "There is no choice at all for a soft diet, you have to have whatever they puree." The managers told us there were two choices for pureed form, but they were not sure if staff always told people of this when they took their meal orders. They were going to check if this had been added onto the order forms. We saw food had been presented well and seemed appetising for people to eat.
● Some people ate their food and had drinks without support, but others were supported by staff. The relatives of people supported by staff to eat said it was done well.
● Any concerns about people not eating or drinking enough were appropriately shared with relevant professionals. This included dietitians and speech and language therapists when people experienced swallowing difficulties. There was evidence staff followed guidance from these professionals.

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

● People told us staff supported them well to access various health services when required. One person said, "A doctor comes here regularly but we can ask the nurse too." Other people told us about seeing dentists and chiropodists too.

● One relative told us their relative's health had improved hugely since they moved to the service. They said this was because of the staff's care and attention, and appropriate referrals to doctors when needed. They added, "The doctor reviewed [person]'s medication and has taken him off [specific medicine]. This was knocking him out and he is much more alert now, smiling and laughing. [Person] was always so pale at the previous home, now he has colour in his cheeks."

● Records showed several health professionals were involved in people's care to ensure they received effective and timely care to meet their needs. The service worked well with professionals to maintain this.

Good

# 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

People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; equality and diversity
● People and relatives told us staff were kind and caring. One person said, "The carers are kind and they are very good to me." Another person said, "People (staff) are kind and helpful, I do like living here."
● People told us they enjoyed mutually respectful and friendly relationships with staff. We saw that the amount of time staff spent chatting with people varied from house to house depending on how busy they were. However, staff always spoke with people politely when they came to communal areas. Some staff had opportunities to sit and chat with people, while others did so briefly on their way to do something else. As part of their role, activities coordinators spent the most time speaking and engaging with people. We observed these interactions were positive and supportive.
● The atmosphere in all houses was calm, compassionate and inclusive. We observed interactions which were gentle and kind in the lounge areas. For example, when two staff members assisted a person to go to the toilet, the person gave one of the them a kiss on the cheek. They were obviously fond of the staff members, smiled and chatted with them on their way to the toilet.
● Some people appeared to enjoy the company of other people living at the service. For example, there was a lot of playful banter between two people sitting next to each other in one house. Others spoke at times with people they sat with, including during mealtimes.
● People told us staff respected their diverse needs and preferences, and they provided care in a way that supported this. Our observations showed staff always treated people in a non-discriminatory way. Staff were able to tailor their interactions with people according to people's interests. For example, a person's love of stroking 'electronic pets' was a source of conversation including with the inspection team. The person appeared to enjoy the attention.

Supporting people to express their views and be involved in making decisions about their care
● People told us they made decisions and choices about their care. Most of them could not remember if they had been involved in planning their care. However, they said staff respected their choices and relatives we spoke with agreed with this.
● One relative said, "Carers always chat with [person] before they move him and tell him what they are doing." Another relative said, "Staff respect peoples' wishes."
● When speaking with a person in their bedroom, we observed a staff member came to ask if the person would like a shower. When the person said "No, definitely not", the staff member accepted this and said they would come back later and ask again.

Respecting and promoting people's privacy, dignity and independence
● People told us that staff supported them in a respectful manner and they promoted their privacy and dignity. People said staff were particularly careful to protect their privacy when providing personal care.

Everyone was happy with how this was done.

● We observed staff paid attention to how people were dressed, and whether they looked presentable or needed support to change their clothing. We saw one staff member was very careful to protect people's dignity when they quickly adjusted their clothing if required.

● People and relatives told us staff supported people to remain as independent as possible in carrying out their daily living tasks. Some people could carry out some self-care tasks without support, while others needed full staff support.

● One house was designated for people who were at the service for short-term rehabilitation. We saw each person had specific goals to help them regain their independence following surgery, a period of ill-health or an injury. The professionals who worked at the service to provide physiotherapy and occupational therapy told us staff worked well with them to help people achieve their goals. Overall, people were discharged within their agreed timeframes, but others stayed longer if required.

Good

# Is the service responsive?

## Our findings

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

People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
● People told us staff provided their care and support in a person-centred way. Staff told us they knew people's needs and preferences, and they did their best to provide care the way people wanted. They also said everyone had been given a choice of whether they wanted to be supported by male or female staff with their personal care. People confirmed this. One person said, "They asked me, but I don't mind. I need the job doing and as long as they are good, that's fine."
● People were happy with the quality of staff support to meet their needs. There were regular reviews of people's care plans, but these did not always identify shortfalls in the quality of information contained in the care plans. However, work had already started in one of the houses to make sure care records contained detailed information about people's needs.
● Some relatives told us they felt involved in their relatives' care because staff informed them if there were changes in their relatives' needs. One relative said, "I am always kept informed if [person] is unwell." They further told us they were happy their relative was receiving treatment for a specific health condition.
● Comments about whether people had enough to do to pursue their hobbies and interests varied from house to house. There were really good interactions with people on some houses, but hardly any on others. The managers told us some houses had new activities coordinators who were not yet as confident as others in planning interesting activities that will entertain and engage most people. There were plans to provide additional training and support to these staff.
● There were also differences in people's abilities to participate in activities, with some houses having people who were more unwell than others. However, we saw evidence that people took part in a range of themed activities, particularly to celebrate specific events. For example, at the time of the inspection preparations and decorations were being put up to help people celebrate Easter.
● One person told us they loved gardening and they spent time doing this with staff.
● One of the activities coordinators said, "I always ask residents what they would like to do, it's more individual. I have plenty of games and I know their likes and dislikes. I spend time with people in their bedrooms, I brush their hair or give them a hand massage. I show them photos and chat about their family." A staff member made positive comments about one of the activities coordinators. They said, "The activity worker is very good, she had a singer come in last week for Mother's Day. She is always interactive with residents, clapping and dancing with them."

Improving care quality in response to complaints or concerns
● The provider had a system to manage people's concerns and complaints. We saw a record of the complaints received by the service and actions taken to investigate and resolve the issues raised.
● People told us they knew who to speak with if they had concerns or complaints. People and relatives said they were mainly happy with service provided and had no reason to complain. Those who had complained, said this had been managed well.

- However, a lack of a system to record complaints in each house meant it was not clear if issues raised by people and relatives were always recorded and formally dealt with. The managers told us they would review this to ensure it was easy for staff to record concerns raised by people before passing the records on to the manager to enter onto the provider's electronic system. It was important this was put in place promptly to give managers a more accurate record of the issues raised about the service.

End of life care and support

- The service provided end of their life care support to many people. Several people came to the service requiring end of life or palliative care. Because of this, there were high numbers of deaths at the service.
- Some people had forms completed by doctors and agreed with them or their relatives, stating that they should not be resuscitated in the event of a cardiac arrest. Staff followed this guidance and there was a system to easily identify these people so that there were no confusions, resulting in delays in treating other people. People's care plans contained this information too.
- As part of their work to review the quality of people's care records, managers told us they would further check that care plans contained up to date information about people's wishes regarding how they wanted to be supported at the end of their lives.

Requires Improvement

# 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

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations were not met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- There had been changes in the management and leadership team which had a negative effect on the quality of the service. Since our previous inspection when we rated the service 'good', there had been two manager changes, the provider's area director had changed, the deputy manager worked part-time and the clinical lead was on long-term leave. Additionally, the new manager had spent time away from the service due to ill-health. This had a de-stabilising effect on the service which resulted in a reduction in the standards of care and governance. The provider was aware of this and had already taken action to recruit a new area director and put additional support to the service.
- Information shared with CQC showed some staff had no confidence in the current management team. Some staff said the manager was good, while others said they were not managing the service well. A few staff said staff morale was poor and they were also concerned that quality monitoring was not as effective as it once was.
- There was evidence of poor governance found during joint local authority and local clinical commissioning group monitoring visits. We also found shortfalls in the quality of the service. For example, there were breaches of regulations because there was a risk people's care could not always be provided safely. This was because care records were not always up to date, legible and accurate. Deprivation of Liberty Safeguards (DoLS) authorisations had expired for most people and applications had not been sent for new people to the service. Other concerns were that incidents had not always been reviewed to enable learning from them. Staff had not had regular supervision to provide them with formal support and to assess whether they had the right skills to support people well.
- Some staff told us they felt unsafe in their roles because the manager was not supportive. Three staff members told us they were concerned that the manager's response to staff raising concerns was to tell them to leave if they were not happy in their jobs. One member of staff told us the manager normally said, "If you are not happy, you know where the door is." We found this did not promote a caring, inclusive and listening culture at the service. It also had the potential to lead to poor care for people using the service.
- Some people and relatives said they knew the manager and they felt she was approachable. They told us they would normally speak to each house manager if they needed anything doing. One person said, "[House manager] is my 'go to person', I will ask her for anything and she will follow it up."

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

- People said they were happy with the quality of their care because nurses and care staff did their best to support them well. However, urgent work was necessary to ensure people's care records reflected their care

needs. Also, managers needed to ensure care plans were of the quality that supported staff to consistently support people safely and effectively. The managers had plans to improve this as soon as possible.
● The service had quality monitoring systems, but these had not been used effectively to drive continuous improvements. Audits had not been carried out regularly since the clinical lead went on leave. This meant the managers could not identify areas of the service that required improvements and make those improvements in a timely way.
● Before the clinical lead went on leave, there had been missed opportunities to empower and support the house managers to take on more responsibilities in completing audits. This would have ensured checks were completely in a more timely way.
● The provider's quality team had carried out inspections and had identified some of the shortfalls in quality we found. There was a plan to make the required improvements as soon as possible. One staff member said, "What is good about HC One is that they come from the Head Office and check records and the environment."

The lack of robust quality assurance meant people were at risk of receiving poor quality care. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● The manager had not always appropriately reported relevant issues to CQC and the local authority. For example, we had not been informed of an incident involving the loss of a significant number of medicine tablets in one of the houses. This meant there was a missed opportunity for the local authority safeguarding team to investigate this or refer the incident to others in a timely way. This did not protect people using the service from potential harm.

This was a breach of Regulation 18 Care Quality Commission (Registration) Regulations 2009.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People and relatives said communication with nurses and care staff was good. Some relatives told us they met with staff and people's social workers to review care. However, most people and relatives said there were now less opportunities for them to provide feedback about the service since the provider changed. Regular meetings were no longer planned.
● One person said, "We used to have meetings, but nothing seems to happen now." One relative said, "They used to have meetings, but there haven't been any for a long time."
● The provider sent a survey to staff in 2018, but not to people using the service and relatives. The manager told us there were preparations to send this out soon. The provider had a newsletter which shared news about what was happening in various parts of the organisation. This also shared important information about the provider's values and ethos. For example, Edition 9 included 'Words are the voice of our thinking'. This was aimed at reminding staff to use respectful words when referring to people using the service, such as, bedrails not cot sides because residents were not children. It was a useful way of sharing good practice. However, further work was necessary as we overheard two staff members calling people who needed support to eat, 'feeders'. This is an undignified and disrespectful term to use.

Working in partnership with others
● The service worked in partnership with health and social care professionals who were involved in people's care. This ensured everyone could check that people consistently received the support they required and expected.
● Since October 2018, the local authority and the local clinical commissioning group had worked closely with the service to help them improve. This was ongoing until the service showed they had put appropriate

systems in place to maintain the required standards of care and practice.

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<br><br>Treatment of disease, disorder or injury | Regulation 18 Registration Regulations 2009 Notifications of other incidents<br><br>The manager did not notify the Care Quality Commission of a significant amount of medicine going missing at the service. This put people at risk of unsafe care. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>People's rights were not always protected. Restrictions on people's liberty had not always been authorised because most of the Deprivation of Liberty Safeguards (DoLS) authorisations had not been renewed.<br><br>Regulation 11(1)(2)(3) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>People were at risk of harm because potential risks to health and wellbeing had not always been managed safely. Care records were not always up to date, legible and accurate to enable staff to provide safe care.<br><br>Regulation 12(1)(2)(a)(b) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or | Regulation 17 HSCA RA Regulations 2014 Good |

| | |
|---|---|
| personal care<br><br>Treatment of disease, disorder or injury | governance<br><br>The provider's quality monitoring processes had not been used effectively to drive continuous improvements. Inconsistent management and leadership of the service had resulted in declining in standards of care and safety.<br><br>Regulation 17(1)(2) |