Care Quality Commission

St. Georges Court Healthcare Limited

St Georges Court Care Home

Inspection report

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26 July 2023

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
St Georges Court Care Home is a 'care home' providing personal and nursing care to up to 76 older people. At the time of our inspection there were 67 people using the service, some of whom were living with dementia. The service has 3 floors and has its own adapted facilities and shared areas for people to use.

People's experience of using this service and what we found
The provider's quality monitoring systems had failed to identify that safeguarding processes were not always followed by staff to keep people safe from poor care. Staff had training but they did not always have the skills and knowledge to promote people's nursing needs, health and well-being. Risks to people were not always considered. People's care plans and risk assessments were not updated quickly enough when there were changes in people's needs, nor did they always contain enough information to guide staff to support people effectively and safely.

Checks for medical devices were not always being completed in line with the manufacturer's directions. Medicines were not always managed safely, and people's privacy and dignity was not always promoted by staff. Lessons were not always learnt. Internal investigations into incidents and accidents failed to identify outcomes, actions and learning to help reduce the risk of harm to people's well-being.

Clinical areas within the service were not always kept clean to promote good infection control practices. Areas of flooring throughout the service were cracked and damaged. This included the laundry room. This meant that the cleaning of these areas to promote good infection control would be more difficult. The layout of furniture and furnishings of the floor that housed people, including people with complex dementia and nursing needs, was not conducive to supporting people who may be noise sensitive. The registered manager told us they wanted to put specialist signage in the service. This would help people who were sensory impaired or were living with dementia find it easier to orientate themselves around the building.

The provider's governance, systems and audit processes were not robust enough. This was recognised by the provider's senior leadership team who told us they were committed to making and sustaining ongoing improvements required. The registered manager and the provider's senior leadership team were responsive to our feedback and engaged with the CQC inspection team fully during the inspection process.

Despite our inspection findings people and their relatives told us they and their family member felt safe at the service. Whilst we observed missed opportunities for staff to meaningfully engage with people, we also saw some kind and considered interactions.

People's needs were assessed prior to them moving into the service. However, people, and their relatives, gave mixed feedback for their involvement in the care planning process. Activities happened at the service, however people living with dementia were not always given enough stimulation to help them spend their day meaningfully. Staff reacted to people's anxieties rather than being proactive to try to reduce the number

of incidents that occurred.

People, and their relatives told us they knew how to raise a complaint. However, verbal complaints were not always formally documented by staff.

The provider undertook safe recruitment procedures. Staff supported people in the main to receive a balanced diet and have enough to drink. However, people's care records contained conflicting information to guide staff. People and their relatives had mixed opinions on whether they were involved in care decisions and reviews.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests.

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

Rating at last inspection
The last rating for this service was good (report published 16 December 2017).

Why we inspected
The inspection was prompted in part due to concerns received by the CQC about safe care and treatment, safeguarding, infection prevention and control, promoting dignity, safe medicines management, and good governance.

We found evidence during this inspection that people were at risk of harm from these concerns. Please see the safe, effective, caring, responsive and well-led sections of this full report.

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

Enforcement and Recommendations
We have identified breaches in relation to safeguarding people from abuse, person-centred care, suitably skilled staff, promoting people's dignity and respect, safe care and treatment, premises and equipment, and good governance at this inspection.

We wrote to the provider during our inspection due to our extensive concerns of people receiving poor quality care. The provider told us they had not been aware of the significant failings at the service and risks posed to people's safety and well-being. The provider submitted a robust action plan to the CQC in response to those concerns.

We have made a recommendation for the provider to review the accessible information available for people. We have also recommended the provider reviews the UK resuscitation council guidelines regarding end of life care information to guide staff.

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

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will

continue to monitor information we receive about the service, which will help inform when we next inspect.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Care Quality Commission

St Georges 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 Health and Social Care Act 2008.

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

Inspection team
This inspection was carried out by 4 inspectors, 3 of whom carried out the site visits. A 4th inspector spoke with relatives by telephone. The inspection team also included 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
St Georges Court Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. St Georges Court Care Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the

quality and safety of the care provided and compliance with regulations.

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

Notice of inspection
This inspection was unannounced.

Inspection activity started on 28 June 2023 and ended on 26 July 2023. We visited the service on 28 June 2023 and 11 July 2023.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and Integrated Care Board who have worked with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 7 people who used the service, and 12 of their relatives about their experience of the care provided. We spoke with 12 members of staff including care workers, nurses, catering staff, housekeeping staff, representatives from the provider's quality team, the care manager, and the registered manager.

We reviewed a range of records at the service. This included training and competency documentation for staff, and staff recruitment records. We also reviewed care records for 11 people during the inspection and some medicines records. We asked for other records to be sent to us, which we reviewed away from the care home. These records included quality monitoring documentation, accidents and incidents, utilities and safety checks, surveys, and the service improvement plan. Additionally, we looked at some policies and other records including the Care Operations Continuity plan.

The chief operating officer for the provider sent us an update regarding the medicines cabinets concerns found during the first site visit. The update included prompt actions taken at the service and throughout the provider's organisation.

Inadequate

Is the service safe?

Our findings

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

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

Staffing and recruitment

● Since the last inspection, the registered manager had improved staffing levels at the service. Staff rotas evidenced the staffing levels planned for each shift. Dependency assessments to determine people's nursing, care and support needs were carried out to establish safe staffing numbers. However, the provider had failed to identify some people's assessed dependency levels were not up to date. For example, a person was documented as being able to walk when they couldn't, so would need more staff support. This inaccurate information increased the risk of the service having unsafe staffing levels.

● The provider had undertaken staff recruitment in recent months. However, they had failed to recognise staff lacked the skills and knowledge to monitor people's known risks safely. For example, 2 nurses we spoke with did not know how to check pressure mattress settings to support people at a higher risk of poor skin integrity.

● The provider had failed to identify staff lacked skills, confidence, and knowledge to effectively support people living with complex dementia. As such, there was a high number of incidents within the service.

● People and their relatives continued to have mixed opinions about staffing levels. A relative told us, "There's definitely a shortage of carers, they need more pairs of hands, then I wouldn't have to go every day. Getting 2 carers at the same time is hard. [Family member] knows [they] can't go to the toilet between 12 noon and 2:30pm because it's lunch time and staff breaks, so sometimes [family member] understands [they have] to wet themselves." Another relative said, "I have observed that the afternoon break from 2pm onwards leaves staff thin on the ground."

There were not enough skilled, experienced, and competent staff to ensure people's safety. This is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following feedback of evidence found during this inspection, the provider had taken actions regarding training and staff competencies to improve staffs' skills and knowledge. However, it was too soon to ensure this support had been embedded and would be sustained.

● The provider undertook specific checks when recruiting staff. These checks helped ensure staff were suitable to work with the people they supported. This included Disclosure and Barring Service (DBS) checks which provide information including details about convictions and cautions held on the Police National Computer. This information helps employers make safer recruitment decisions.

Assessing risk, safety monitoring and management; Using medicines safely; Preventing and controlling infection

● The provider did not make sure people's known risks were documented in detail to guide staff on how to nurse and care for people safely. The monitoring and management of people's known risks was not robust.

We found a medical device had not been safety checked in line with the manufacturer's guidelines, until identified during this inspection. This had placed people at an increased risk of harm as staff could not be confident the device was working appropriately.

● The provider had failed to identify staff had not responded to people's known risks promptly. Staff failed to review and update a person's risk assessment to clearly guide staff, following the person's discharge from hospital. The information missing was around a medical device used to promote their well-being and a newly identified significant risk. Thus, putting the person at an increased risk of poor care. Only during this inspection, 6 days after the hospital discharge, were actions taken to record the new and increased risks to this person.

● Staff had failed to review the same person's risk assessment around their increased risk of choking. Records stated the person was low risk. This was not accurate, and this incorrect information significantly increased the risk of harm to the person.

● The provider had failed to identify staff were not documenting people's wound care in a consistent manner. This meant there was an inconsistent and unclear approach to wound care monitoring. Risks were increased to people because of staffs' failure to keep accurate records of whether the wound was healing or deteriorating.

● Medicines were not always managed safely. Medicines stock tallies were not always accurate. Staff had failed to identify all anticipatory medicines prescribed for a person who was at the end of their life had been received. All 4 medicines had been delivered to the service, but on speaking to staff they were only aware of 2. This meant the medicines receipt and booking in system and storage of people's prescribed medicines were not robust enough or accurate. This lack of provider oversight increased the risk of the person not receiving the prescribed medicines they may have needed to ensure they had as dignified and pain-free death as possible.

● The provider had failed to identify staff did not always act promptly following people's medicines changes. Staff had not acted quickly to a person's insulin changes following a diabetic clinic review. The service had received the changes required via email on 4 July 2023. However, staff only reacted to the changes required following a follow up telephone call on 11 July 2023. The delay in staff implementing these changes increased the risk to the person's well-being.

● The provider had not identified the medicine cabinets in people's rooms to hold their prescribed medicines could be unlocked by keys other than those supplied with the cabinets. The registered manager also told us that there was no formal 'booking in and out' of these keys and the keys could be taken off site by staff. The provider took prompt and robust action within the service and organisationally when we made them aware of our significant concerns.

● The provider was not promoting safety through the layout and hygiene practices of the premises. The laundry room floor and other floored areas within the service were damaged in areas which would make the cleaning of it to reduce the risk of cross contamination difficult.

● The medicines room on the ground floor was unclean in areas including the floor, the air conditioning unit, and the light pull cord. Medicines rooms are clinical rooms which should be cleaned to a high standard to promote good infection control.

● The provider was not supporting people living at the service to minimise the spread of infection. During the first inspection site visit, we observed a person sat in their room eating, whilst soiled bedding was left in the room. A relative told us, "[Staff] leave soiled washing in the bin in the bedroom and it smells, so now we take [family members] washing and do it."

Assessments had not been completed promptly to ensure they were up to date or were not robust to mitigate risks to people. The provider's monitoring of people's safety was not always robust to keep people safe including safe medicines management and good infection control practices. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

● The provider did respond to the concerns raised. However, it was too soon to ensure the actions being taken had been fully embedded and would be sustained.
● Despite the inspection findings, people, and their relatives in the main had positive opinions of how staff managed medicines. A relative said, "Medicines are given on time and always checked and recorded. This is important because some of my [family member's] meds are time critical."

Visiting in care homes
● The provider encouraged people's relatives and friends to visit the service. Observations during our 2 inspection site visits corroborated this. Staff made people's visitors feel welcome. A relative confirmed to us that, "[Staff are] always quick to smile and say hello when we visit and share their thoughts on how [family member] is."

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● The provider had not identified staff did not follow their safeguarding training. Nor had staff always followed the provider's process in place to protect people from the risk of harm or poor care. During this inspection, we raised multiple concerns with the local authority safeguarding team around neglect, poor care, and harm.
● Lessons were not learnt in a timely manner. Incident and accidents were not always recorded promptly or accurately. The provider had failed to identify that some staff lacked insight into the importance of open, transparent, and prompt recording of incidents and safeguarding. During our site visit of 11 July 2023, we found 2 people had unexplained bruising that was known, but not formally recorded by staff. Staff had failed to learn from our feedback during the first site visit on 28 June 2023. This included the importance of robust management and reporting of incidents, poor care, and harm.
● The provider and staff team had failed to recognise staff had not followed their falls policy. Staff had not monitored a person following a fall for any head injuries or pain. The person was found later to have fractured a bone. An investigation report into the incident failed to identify any outcomes, actions, or any lessons learnt from this review. This lack of insight placed people at risk of unsafe care and harm.
● Staff had failed to take prompt action following an upheld safeguarding investigation around constipation management for a person, to help identify other people at risk. This failure meant lessons had not been learnt and swift action had not been taken to review all people's 'as required' medicine protocols. Care plans continued to lack detail to guide staff on when to administer laxatives and at what dose.

The provider's oversight and systems were not robust to protect people from abuse. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following feedback of evidence found during this inspection, the provider had taken actions regarding staff knowledge and insight around safeguarding concerns and reporting. However, it was too soon to ensure this support had been embedded or sustained.
● Despite our findings, people and their relatives said they, or their family member, was safe. A person told us, "I feel safe living here." A relative said, "I don't think that safety is ever an issue, [family member] is safe in this place and they are safe with carers, I have no concerns about that at all."

Requires Improvement

Is the service effective?

Our findings

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

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

Adapting service, design, decoration to meet people's needs
● Not all areas of the building were suitably laid out to meet people's needs. The nursing dementia floor of the service was not suitable in its layout and or design for people. This included people whose anxieties may be triggered by loud noises or for people who were noise sensitive. The care call system sounded quite piercing at times and trollies used to transport laundry or medicines rattled loudly on the flooring.
● The nursing dementia floors communal lounge had seating set out and some of the seating was facing backwards to the television which was on.
● The provider had failed to identify high-risk areas of the service such as sluice rooms where chemicals were kept, and electrical cupboards were not always locked to make sure people did not unknowingly come to harm.
● We also found thickening powder had not been securely put away. Again, this increased the risk of harm to people.

The adaptation, design, and safety of areas within the service did not always meet people's needs and promote their safety. This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following feedback during this inspection, the provider took action to make sure all areas, rooms and cupboards that should be locked by staff were. However, it was too soon to ensure this had been embedded or sustained.
● The provider and staff team encouraged people to bring in items to personalise their bedrooms to their taste.

Supporting people to eat and drink enough to maintain a balanced diet
● Staff supported people in the main to eat and drink enough. However, people's risk assessment around safe support for food and drink was sometimes inconsistent. There was conflicting information to guide staff in people's care plans and risk assessments. A relative told us that when visiting their family member, the food had not been cut up by staff in line with external professional guidance. They said, "So I cut food for [family member] and help by feeding [family member]. I don't know what would have happened if I am not here."
● We observed a person who needed an adapted beaker when drinking was not provided with this. This increased their risk of choking.
● The fridge on the ground floor kitchenette contained food that was not covered or dated when opened.

This meant there was an increased risk of food being eaten that was out of date or spoiled due to not being covered.
● The majority of people and relatives spoken with had positive opinions about the food at the service. A relative confirmed, "The food is cooked on site with fresh ingredients; there is always a choice of menus and plenty of snacks on demand."
● However, some people told us they felt the vegetarian options could be more varied. A relative said, "There is only one choice, (a) meaty version and vegetarian…Often there is too many versions of potatoes and no proteins. Like today there is mash potato and roast potato, no cheese, or fish so there are no proteins on this plate."

Staff support: induction, training, skills, and experience
● The provider's governance systems had identified staff supervisions and appraisals were not up to date. Actions were being taken to make this improvement.
● Staff received training based on people's needs. Competencies were also undertaken to help ensure that staff member's knowledge following their training was embedded. However, the provider had failed to identify there was a skills and knowledge gap for some staff in, but not limited to; dementia care, nursing care, and safeguarding. This increased the risk of poor care and harm to people.
● New staff completed an induction when starting their role. Inexperienced staff also completed The Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The registered manager and management team assessed people's needs in line with guidance and legislation, prior to them living at the service. Assessments included the review of people's risks and preferences.
●The registered manager told us they were looking closely at whether the staff at the service could fully meet the needs of people with complex dementia and nursing needs.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● The provider and registered manager made sure there were a variety of health professionals such as GP's, and speech and language therapists involved with people's care. A relative confirmed to us, "My [family member] is referred to other professionals and the GP when needed." However, staff did not always react to health professionals suggested changes for people quickly enough.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. 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 appropriate legal

authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● Staff had received training to ensure their understanding of the MCA and DoLS, and we observed staff offering people choices.
● People and their relatives had mixed opinions about the choices, they or their family member were given. A person told us, "I do feel safe because I feel free to do what I want, get up when I want, and staff ask constantly what I want, and they help or bring what I asked them to do for me."
● However, a relative told us that during the inspection, "My [family member] was there today and at lunchtime staff came in with 2 plates of food and asked [family member] which [choice they] would like. We've never seen that before."

Requires Improvement

Is the service caring?

Our findings

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

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

Respecting and promoting people's privacy, dignity, and independence
● Staff did not always respect and promote people's dignity. The provider had failed to identify that not all language used in people's care records promoted their dignity. We shared with the registered manager examples of disrespectful language used in people's care records.
● Whilst staff used signs to show personal care support was being delivered in people's rooms, we also observed a staff member supporting a person with their toileting needs with the door wide open. The staff member lacked insight into the importance of promoting and respecting people's dignity.
● People and their relatives had mixed opinions about the laundry service. Whilst positive comments were shared, we were also told how lost clothes did not always promote people's dignity and respect. A person said, "When my clothes are lost, I don't like that. Very often happens, and it's not nice. Sometimes I have to wear other people's clothes…my 6 new [items of underwear] disappeared, and nobody can find them." A relative told us, "Often [family member's] clothes go missing and few days ago [they] had somebody's pink top with sparkles. Definitely not [family member's]."

The provider's oversight and systems were not robust to protect people from undignified and respectful care and support. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following feedback of evidence found during this inspection, the provider had taken actions to educate staff that people were to be always cared for in a respectful and dignified manner. However, it was too soon to ensure this had been embedded or sustained.
● Despite our inspection findings, people and their relatives told us staff did respect them or their family member. A relative said, "Staff treat my [family member] with dignity and respect and see to all [their] needs."

Ensuring people are well treated and supported; respecting equality and diversity
● Staff did not always recognise and respond to opportunities to provide people with reassurance and support. We observed missed opportunities of staff engaging with people in a meaningful way.
● However, we also saw many positive staff interactions which were respectful, kind, and considerate.
● People and their relatives had mixed opinions about the kindness of staff. A person told us, "Some of the carers could be off hand, a little (brusque), but most of them are alright." However, a relative confirmed to us, "I'm so at peace with how they treat my [family member] and I wouldn't want [them] to be anywhere else."

● In the main staff respected people's equality and diversity. However, a staff member was overheard referring to a person by a name they had asked not to be called by. This request by the person was clearly recorded in their care record.

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

● People and their relatives had mixed opinions about how involved they felt in their, or their family members care and care decisions. A relative said, "I get a call every month and they tell me [family member] is 'resident of the day'. They go through the care plan with me, and we talk about any problems with it." However, another relative told us, "I don't know anything about [family member's] care plan."

● People's care records did not document whether they, their relative, and or advocate had taken part in decisions around the care provision. These included reviews of people's, nursing, care, and support needs to make sure they were up to date.

● A staff member was observed to enter a shared lounge and turned the television over without any consultation or conversation with the people sat in the room.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed 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
● The provider had not identified the new computerised care planning system introduced into the service, did not have up to date and detailed information about people. This included their individualised known risks or nursing needs, to guide staff. For example, people with complex dementia did not always have their identified individualised behaviours that could be triggered by their dementia diagnosis and or increased anxieties documented to guide staff.
● The provider had failed to identify people did not always receive basic personal care support such as nail care. We saw some people with long nails and toenails. We observed a person with dirty nails touching their face and eyes which significantly increased the risk of infection.
● The provider had failed to support people to receive basic oral healthcare. Some relatives told us about their concerns around the lack of oral healthcare. A relative said, "I clean [family member's] teeth when I come twice a week, otherwise I don't know if they do clean them when I am not there. I would like [their] teeth cleaned as for everybody twice a day and I would like to have that documented so I can see it's done when I come."
● Some people told us their preference was to have baths to help promote their well-being. A person said, "I only have bed wash because not a big enough shower chair or wheelchair, I would love to have a bath." Another person told us, "I would prefer a bath, but staff often say there is no time…I did insist 1 day…but there was not enough hot water. I would do it again as long as they have hot water."

The provider's lacked oversight to identify that basic and person-centred care was not always being provided. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following feedback of evidence found during this inspection, the provider had taken actions to remind staff of the importance of supporting people with person-centred care. However, it was too soon to ensure this support had been embedded or sustained.

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

● People living with dementia had limited orientation aids available within the service. This increased the risk of people being disorientated because the environment had not been fully designed to meet their needs.

The registered manager told us of their plans to improve the signage around the service, including dementia friendly signage. We recommend the provider place appropriate accessible signage within the service at their earliest opportunity.

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
● Activities were held in the service to support people with their interests. People and relatives had mixed opinions on whether there were enough activities to keep people stimulated and meaningfully occupied. A relative told us, "They do a lot of activities. PAT (Pets as Therapy) dogs visit, and they have someone who sorts out the activities." However, another relative said, "I would like my [family member] to be able to mix with more of the other [people] on the other 2 floors. [My family member] needs to be able to interact with more than just the same 4 or 5 every day."
● We observed that for people with complex dementia, there was not always enough stimulation and activities to keep them occupied in a meaningful way.

Improving care quality in response to complaints or concerns
● The provider had a complaints policy, and information was available on how to raise a concern. Records showed formal complaints had been received and responded to.
● However, this had not always been effective. We received mixed feedback from people's relatives in relation to their experience of raising concerns and complaints verbally to staff and if they had been addressed.
● Compliments about the service had been received.

End of life care and support
● People had end of life care plans in place that documented their wishes should they choose to discuss this. However, these records needed more information to guide staff as to people's end of life wishes. This included information about a person's spirituality, any anticipatory medicines prescribed and oral healthcare to guide staff.
● People had 'do not attempt resuscitation' forms in place. These recorded people's wishes on whether they would choose to be resuscitated or not should their health significantly decline. However, we found a form had contradictory information about a person's wishes recorded. This unclear information increased the risk of the person's wishes not being followed by staff.

We recommend that the provider follows the UK resuscitation council guidelines to help ensure staff have enough and accurate information about people's end of life wishes.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed 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.

Promoting a positive culture that is person-centred, open, inclusive, and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
- The provider, registered manager and senior leadership team had undertaken quality monitoring and audits prior to this inspection. A service improvement plan was in place to make the improvements found. However, although the quality monitoring of the service had identified some areas requiring improvement, specific and significant areas of concern found during this inspection had not been identified.
- There had been a lack of managerial leadership and guidance to ensure people's health and care needs were assessed, reviewed, and effectively met. The had been a failure to identify people's care records were not up to date and were inaccurate.
- We found serious shortfalls in relation to safeguarding people from harm and safely managing people's known risks that had not been identified by the governance monitoring systems.
- The provider had failed to identify that some medical devices had not received safety calibration checks in line with the manufacturer's guidance. The provider's audits had also failed to identify people's medicines were not always managed safely and effectively.
- The provider had not recorded all incidents and accidents robustly or in a timely manner. They could not evidence a robust investigation into a fall that had occurred. The recorded lessons learned did not cover all the identified issues and this failure meant that lessons were not learnt to reduce the risk of recurrence.
- The provider's governance systems had failed to identify that people's privacy and dignity was not always promoted and that basic care support for people did not always take place.

Governance and quality checks were not always effective in identifying areas for improvement. This meant effective action was not always taken quickly to improve the quality-of-care people received. This is a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We wrote to the provider during our inspection due to our extensive concerns of people receiving poor quality care. The provider told us they had not been aware of the significant failings at the service and risks posed to people's safety and well-being. The provider submitted a robust action plan to the CQC in response to those concerns.
- The registered manager held meetings with people, their relatives, and staff. These meetings provided opportunities for people, relatives, and staff to share their thoughts and feelings and allowed the registered

manager to be aware of areas for improvement. A relative told us, "I have always had a positive response when I have had occasion to talk about any concerns that I may have."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The provider understood the requirements of the duty of candour. This is their legal duty to be open and honest about any accident or incident which caused or placed a person at risk of harm.
● The provider, after they received feedback following the inspection, told us they had contacted all service users and or their relatives and advocates to make them aware of the improvements required. This included the actions they intended to take to remedy any shortfalls in the service provided.

Working in partnership with others

● The registered manager and staff team worked with external professionals such as GP's, chiropodist and speech and language therapists.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider lacked oversight to identify that basic and person-centred care was not always being provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider's oversight and systems were not robust to protect people from undignified and respectful care and support.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Assessments had not been completed, or completed promptly, to ensure they were up to date, or were not robust enough to mitigate risks to people. The provider's monitoring of people's safety was not always robust to keep people safe including safe medicines management and infection prevention and control.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider's oversight and systems were not robust to protect people from abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The adaptation, design, and safety of areas within the service did not always meet people's needs and promote their safety.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Governance and quality checks were not always effective in identifying areas for improvement. This meant effective action was not always taken quickly to improve the quality-of-care people received.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough skilled, experienced, and competent staff to ensure people's safety.