Quality Care Management Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Quality Care Management Limited is a care home which provides personal and nursing care for up to 38 people, aged 55 and over. Most people living at the service are living with dementia or another cognitive impairment. At the time of the inspection the service was supporting 30 people.

The care home accommodates people in one adapted building.

People's experience of using this service and what we found
At this comprehensive inspection we found five breaches of regulations. There were systemic failings identified during this inspection that demonstrated a significant deterioration in the quality and safety of the service since its last focused and comprehensive inspections.

The provider failed to ensure effective oversight of service provision. Quality and safety monitoring systems were ineffective in identifying and directing the service to act upon and mitigate risks to people who used the service and ensure the quality of service provision.

People were at risk of neglect and unsafe or inappropriate care or treatment. We observed staff ignoring people and poor moving and handling practices.

People were not always treated with dignity and respect; some people told us staff were not always kind to them. Although family members were positive about the service, we observed occasions when staff treated people without compassion and kindness.

Staff said they knew how to prevent and report abuse. We were concerned however, that staff practice which amounted to omissions of care had not been considered as neglect.

There were not enough sufficiently skilled staff to meet people's needs. There was a high reliance on agency staff; we observed the staff on duty lacked the skills and knowledge to care for the people living at the home. People therefore did not receive person centred care.

Not all staff had received all necessary training and there were no formal supervision processes occurring. We were not assured of quality of training received given the widespread failings found at this inspection.

Medicines were not always administered as prescribed and there was a lack of guidance for staff in respect of topical creams. Infection prevention and control measures were not always followed by staff.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. The principles of the Mental Capacity Act 2005 were not being applied in

respect of best interest decisions to provide care or use restrictive practices.

Staff, people and visitors gave varied feedback about the service. Our observations of how care was provided to people were reflective of the varied feedback.

We found errors and discrepancies that had not been identified by the quality assurance systems in place. Care plans and risk assessments had not been updated, were not consistently person centred and lacked detailed guidance for staff to ensure people received care in a person centred and safe way. Risk assessments that related to people's health, safety and the environment did not ensure all risks were effectively assessed.

Staff were positive about the management team. The provider had appropriate staff recruitment procedures. The management team sought advice and guidance from external professionals where required.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection and update
The last inspection (report published 23 October 2020) was a focused inspection covering safe and well-led. Although these key questions were rated good the overall rating remained Requires Improvement as the ratings from the previous inspection (published 17 October 2019) for the remaining key questions were used to calculate the overall rating for the service. This service has been rated requires improvement for the last seven consecutive inspections.
At this comprehensive inspection the service has been rated inadequate.

At our last focused inspection in September 2020 we recommended the registered person consider contingency arrangements to ensure records can be maintained during difficult times. At this inspection we found that some care plans and risk assessments had not been updated to fully reflect people's changing needs.

In July 2019 we also recommended the registered person seek advice from a reputable source to ensure the application of the Mental Capacity Act 2005 is applied and recorded consistently and accurately. At this inspection we have found continuing concerns with the application of the MCA.

In July 2019 we also recommended the provider seek advice and guidance from a reputable source about creating a stimulating environment for people who are living with dementia. At this inspection we found further work to ensure the environment is suitable and stimulating for people living with dementia was required.

At our last comprehensive inspection in July 2019 we recommended the registered person review the deployment of staff to ensure this met the needs of people, especially those who were unable to use a call bell. We did not find any concerns with the deployment of staff at this inspection.

Why we inspected
We undertook this inspection as part of a random selection of services which have had a recent Direct Monitoring Approach (DMA) assessment where no further action was needed, to seek assurance about this decision and to identify learning about the DMA process.

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.

We found evidence the provider needs to make improvements. Please see the relevant key question sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Quality Care Management limited on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in risk assessment, medicines management, infection control, staff training, the Mental Capacity Act 2005, treating people with dignity and respect and quality assurance at this inspection.

We have cancelled the provider's registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Quality Care Management Limited

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 conducted by four inspectors.

Service and service type
Quality Care Management Limited 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. Quality Care Management Limited 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 service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. At the time of our inspection there was a registered manager in post.

Notice of inspection

This inspection was unannounced.

What we did before the inspection
We reviewed the information, we had received about the service, including previous inspection reports and notifications. Notifications are information about specific important events the service is legally required to send to us. We also used information gathered as part of the monitoring activity that commenced on 28 February 2022 and was completed on 16 March 2022 to help and inform our judgements.

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 five people who used the service and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We received feedback from four family members and three external professionals.

We spoke with 12 members of staff including the registered manager, the providers representative, the deputy for the nominated individual, nurses, care staff, laundry staff, catering staff and the activities coordinator.

We reviewed care plans for seven people and records of care provided for 11 people. We looked at staff files in relation to recruitment and records relating to staff training. A variety of records relating to the management of the service, including audits, policies and procedures were also reviewed.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection this key question was rated as good. At this inspection this key question has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

● At the last focused inspection completed in September 2020 inspectors highlighted concerns in relation to the management of topical creams. At this inspection these issues were continuing.

● Topical medicines administration records (TMAR) were not in place for all people who required the application of creams and lotions. The lack of TMARS meant there was no guidance available to staff in relation to the frequency of cream application and where on the person's body this was to be applied. This meant that people may not have received creams as required placing them at risk of developing or exacerbating skin conditions.

● We viewed topical creams stored in five people's bedrooms. These creams were not labelled with the date of opening or expiry, this meant staff would not know when to discard these when they were no longer be safe to use. Additionally, within one empty bedroom we found an open topical cream that had past the manufacturer's expiry date by over five months. We were told the bedroom had been vacant for about a month.

● People did not always receive medicines as prescribed. Medication administration records showed nursing staff did not always return to try to administer medicines if the person was asleep when medicines were due to be administered. This was the case for some once a day medicines which could have been given later in the morning when the person was awake.

● Some people were prescribed medicines to be given several times a day. There was no procedure in place to accurately record the exact time these were given meaning subsequent doses could be given too soon resulting in overdose. For example, several people were prescribed paracetamol four times a day with at least four hours required between administration. Nursing staff agreed there was a risk these could be given a second time within a four-hour window.

● For some, but not all 'as required' (PRN) medicines there was guidance as to when this should be administered, and a record kept of the effectiveness of administration. However, for other PRN medicines this was not the case. For example, one person was prescribed PRN Lorazepam for when they were agitated. There was no plan to guide nursing staff as to when this should be given, and no record kept of the effectiveness of the outcome of administration. This placed the person at risk of receiving the medication inconsistently and meant medical staff would not have the information they required to review the prescription.

● A record was kept of the temperature of the storage areas including the fridge for medicines. However, this only reflected the temperature at the time of recording and the thermometer in use did not include the maximum and minimum temperatures since the previous recording. This meant there was a risk nursing staff would be unaware if temperatures had exceeded the safe limits and medicines may be unsafe to use.

The failure to ensure safe management of medicines was a breach of Regulation 12 (Safe care and treatment) (Regulated Activities) Regulations 2014.

● The concerns highlighted at the inspection were brought to the attention of the management team and nursing staff who agreed action would be taken to address this. By day two of the inspection we saw action had been taken and these issues had been addressed.
● Medicines were administered by trained nurses who told us they had received additional training and an annual competency assessment in respects of medicines management were undertaken.
● There were systems in place to ensure medicines were stored securely and medicines that have legal controls, 'Controlled drugs' were appropriately and safely managed and monitored.

Preventing and controlling infection
● Infection prevention and control procedures were not always managed safely.
● We found some areas of the home and some equipment were poorly maintained, so could not be effectively cleaned. This included, some fixtures such as shelving, moving and handling equipment and floor coverings. This was discussed with the provider's representative and registered manager who told us action would be taken to address this.
● We saw staff were wearing appropriate PPE, however throughout the inspection we observed some staff not following national guidance on the wearing of face masks. Staff were seen wearing their face mask under their chin and below their nose. This meant the PPE was not fully effective and there was a risk infection could be more transmissible. This practice continued even when it was brought to their attention by inspectors.
● We were not assured laundry was managed in a safe way. We observed unsafe practices in the management of potentially contaminated laundry meaning clean items could become contaminated before they were returned to linen stores or people's bedrooms. This placed people at risk of infection.
● We were not assured that all contaminated waste was managed safely. Whilst in most areas there were foot operated (pedal) bins the waste bin within the laundry area had to be opened by hand meaning staff risked contamination when opening the bin to place soiled items inside. Larger containers used to store clinical waste pending collection were not locked and for one the lid would not close fully.
● Although infection prevention and control audits had been completed these had not identified the concerns, we found on inspection meaning the necessary improvements had not been made.

The failure to ensure infection and prevention control measures were effectively managed was a breach of Regulation 12 (Safe care and treatment) (Regulated Activities) Regulations 2014.

● We were assured that staff were accessing testing for COVID-19 following government guidelines.
● We were assured that the provider was admitting people safely to the service. The providers representative described the home's admission procedures, and these followed the appropriate government guidance and included a COVID-19 test being completed and admissions preceded only if a negative result was obtained.
● We were assured the provider was supporting people to receive visitors. A booking system was in place however, the provider's representative told us they would be as flexible as possible, and end of life visiting would be unrestricted. Two family members told us they were able to visit twice a week and were happy with the arrangements in place for safe visiting.

Assessing risk, safety monitoring and management
● Risks were not always managed and mitigated effectively.
● Safe moving and handling practices were not followed placing people at risk of harm. On day one of the

inspection we observed on two occasions staff supporting people to stand from a sitting position. Staff pulled these people up from the waist band of their trousers and under their arms, this was not only unsafe and could cause pain and/or injury to people but was also undignified. Additionally, this was all done without any communication with people.

● On day one of the inspection we saw people being supported to walk by staff in an unsafe way. For example, staff were observed to be pulling on a person's arms and walking at a pace that was too quick for the person; the person being supported appeared to be losing their balance and the staff member pushed them into a chair to prevent them from falling.

● Care records including risk assessments did not provide clear and consistent information in relation to people's needs. For example, we reviewed the care records of three people who were cared for in bed and were therefore at risk of harm from skin damage. Information was not always in place or was conflicting to describe the level of support they required to change their position or how frequently repositioning should be completed for each person if required. Some of the repositioning charts showed people's positions were not changed in accordance with their care plan. For one person whose care plan clearly stated they should not be positioned on their left side repositioning charts noted this had occurred. Therefore, we could not be assured risks to people were managed and mitigated effectively.

● We asked the registered manager to clarify the information in the care plans and they informed us the care plans contained out of date information and would update this immediately. The failure to keep care plans up to date meant people were at high risk of receiving incorrect care, exacerbating existing health risks or placing them at risk of new concerns such as skin breakdown.

● When we identified that some individual risk assessments such as for blood thinning medicines and flammable topical creams were not in place prompt action was taken by the management team to add these to care files.

● Where individual risks had been identified staff did not always follow guidance to maintain people's safety. We saw a sign in one person's bedroom stating the bed control should not be given to the person. However, the control had been left on the side of the bed and in reach of the person. We brought this to the attention of the staff member present at the time.

● Environmental risk assessments and safety audits can be used to help identify safety concerns and provide a clear and detailed plan of actions required to keep people safe. However, we identified aspects of the environment were not safe. For example, some areas of the home were cluttered and this prevented access to gas safety valves which was a fire safety risk; some flooring was torn and ripped, resulting in a falling hazard and doors containing hazardous chemicals were not always locked and were accessible to people. An asbestos hazard risk assessment had not been undertaken. These issues were discussed with the providers representative and registered manager who agreed to act. On day two of the inspection some work had been done to address some of the issues identified.

The failure to ensure risks to people and environmental risks were effectively managed was a breach of Regulation 12 (Safe care and treatment) (Regulated Activities) Regulations 2014.

● Equipment, such as hoists, lifts and fire equipment were serviced regularly. Gas and electrical safety certificates were up to date.

● Personal emergency evacuation plans had been completed for each person, detailing the action needed to support people to evacuate the building, in the event of an emergency.

Staffing and recruitment

●There were appropriate numbers of staff available to meet people's needs and requirements in a timely way. However, we were not assured the staff available to people had enough skills, knowledge and experience to keep people safe.

● On day one of the inspection it was noted that 10 of the 11 care staff available to people were not directly employed by the service but were sourced from local agencies to make up staff shortfalls. From discussions with these staff and our observations it was evident these staff members did not understand people's needs and conditions and were unaware of how best to support the people living at the home. This is further reflected on in the effective and caring sections section of this report.
● Staffing levels were determined by the number of people using the service and the level of care they required. The registered manager kept staffing levels under review and used a formal assessment tool to determine the numbers of staff required to meet people's needs.
● People and relatives told us there was sufficient staff available to support people. A person said, "Staff are usually quite responsive when I press the buzzer, they usually come quite quickly." We also observed a person pressed their call bell and this was responded to quickly.
● We discussed the high level of agency staff usage with the registered manager and the providers representative who confirmed they were finding it difficult to recruit permanent staff. The provider's representative was taking active steps to employ permanent staff and had arranged to have a stall at the local job centres to encourage new staff into the service.
● There were safe recruitment procedures in place to help ensure only suitable staff were employed. This included disclosure and barring service (DBS) checks, obtaining up to date references and investigating any gaps in employment. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable people. The provider obtained information from employment agencies to confirm that agency staff recruitment checks had also been completed.

Systems and processes to safeguard people from the risk of abuse
● We received mixed views from people about whether they received safe care and treatment. One person said, "I'm concerned about my treatment, I'm frightened to look at staff." However, another person told us, "I'm really happy and feel very safe."
● Not all staff had completed training in safeguarding adults from abuse. When safeguarding issues were discussed with staff they were not all able to demonstrate they understood how to recognise abuse and the action to take if they had concerns. Other staff directly employed by the service did understand their safeguarding responsibilities and appropriately described the action they would take including contacting external agencies if required.
● The management team knew what constituted safeguarding and there were processes in place for investigating any safeguarding incidents. Where these had occurred, they had been reported appropriately to CQC and the local safeguarding team. However, during the inspection we observed some staff supporting people in a way which did not represent appropriate care or procedures and was placing people at risk of harm. This is further discussed in the caring and effective sections of this report.
● Following the inspection, we contacted the local authority safeguarding team and informed them of the concerns we identified during this inspection.

Learning lessons when things go wrong
● Accidents and incidents were recorded and monitored to identify any trends or gaps in service delivery. Where necessary action was taken to reduce the likelihood of repeat incidents such as the use of movement alert equipment to enable staff to respond promptly to a person at high risk of falls moving around in their own room.
● Records showed that advice and guidance had been sought and information shared with relevant professionals following accidents or incidents.

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

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.

● At the last comprehensive inspection completed in July 2019 we recommended the registered person seek advice from a reputable source to ensure the application of the MCA was applied and recorded consistently and accurately. At this inspection these issues were continuing.
● People told us they were not always consulted before care was provided. One person told us "They [care staff] just do things but don't really ask us about it like we're not even here."
● Throughout both days of the inspection we constantly observed staff not seeking people's consent or informing them of actions they planned to take prior to moving the person or making changes that affected the person. For example, we observed a staff member placing a table in front of a person without any explanation of what they were planning to do. The person's legs were in the way, so the staff member used the bar on the bottom of the table (on the floor) to open the person's feet and put the table in place. This was all done without any attempt to communicate with the person to gain consent or any explanation of what they were doing. Numerous other similar examples were observed during the inspection.
● Documentation did not consistently demonstrate people's mental capacity to consent to care or treatment had been appropriately recorded in line with legislation. Mental Capacity Assessments were unclear and were not always decision specific.
● Many people living at the home had a diagnosis of dementia and were unable to fully understand and therefore make an informed decision when consenting to care and treatment. The MCA is clear that assessments of a person's capacity must be decision specific as people may be able to consent to some

aspects of their care but not others. For example, nursing staff were responsible for the administration of medicines for all people. They confirmed where people lacked the capacity to make an informed decision about their medicines (understand what the medicines were for, what the possible benefits and side effects may be) no decision specific mental capacity and best interest decisions for medicines administration had been made.

● The correct MCA procedures had also not been followed where people may require support with personal care. For example, one person's care plan detailed that on occasions they may require the support of up to four staff to enable personal care to be provided as the person would physically refuse to have personal care provided on some occasions. A staff member explained the reason for this as needed one staff member to talk with the person, one to hold the person's hands and the other two to complete personal care. We discussed this with the registered manager who told us no decision specific mental capacity assessment followed by a best interest decision had been completed for the provision of personal care for this person who lacked the capacity to consent to personal care. This meant this person was being unlawfully restrained.

● A person's care file included a document in respect of admission to hospital. This stated that a relative holding the power of attorney had made the decision in the person's best interests that they should only be admitted to hospital in specific circumstances. Although there were documents confirming the relative had power of attorney there had been no mental capacity assessment of the person's ability to make the specific decision prior to the best interest decision by the power of attorney.

The failure to ensure the Mental Capacity Act 2005 and associated code of practice is followed on all occasions where a person lacks mental capacity to make an informed decision, was a breach of Regulation 11 (need for consent) (Regulated Activities) Regulations 2014.

● The management team understood their responsibilities in terms of making applications for deprivation of liberty safeguards (DoLS) as required. There were systems in place for monitoring these and ensuring they were kept up to date.

Staff support: induction, training, skills and experience

● Not all staff had received the necessary training to enable them to safely meet people's needs. For example, we asked one permanent staff member about safeguarding and infection control training and they told us, "Not since I have been here, but had it at the last place I worked."

● From our observations and conversations with staff it was evident some staff lacked the skills, knowledge and understanding of people's needs and how to safely and appropriately manage these needs. For example, some staff were unable to describe the procedure they should follow if the fire alarms sounded. We observed staff supporting people to move around the home using inappropriate and potentially dangerous techniques.

● The provider's training records showed not all staff directly employed by the service had received adequate training in a timely way to equip them to do their roles, safely and effectively. For example, gaps were noted in the completion of safeguarding training, moving and positioning training, infection control training and fire safety training. These gaps demonstrated for some staff training had not been received at all or was considerably out of date. This was discussed with the provider's representative who confirmed more work was needed to ensure training was up to date.

● At the time of the inspection the service was reliant on a high use of agency staff, to help ensure safe staff numbers were available. The service had received evidence from the agencies that the staff were appropriately trained. However, from observing these staff members practice and talking with them, it was clear that they did not understand some aspects of the training they had received, placing people at risk of harm.

● Prior to the inspection this had been identified by the provider's representative who had attempted to take action to address this. The provider's representative showed us emails sent to the agencies about the concerns in relation to staff skills and behaviours. They had declined to have some staff members offered by the agency and were encouraging others to do additional training, provided by the service. However, we continued to observe poor practice as detailed above and in other sections of this report.

The failure to ensure all staff have the necessary training, knowledge and skills to safely meet people's needs was a breach of Regulation 18 (staffing) (Regulated Activities) Regulations 2014.

● The registered manager explained the induction process for new permanent staff. This included two weeks of shadow/supervised practice and the completion of online and workbook training. New permanent staff also completed some practical training such as moving and handling with a local care training provider. A permanent staff told us the induction was, "Fine and covered what was needed." Agency staff new to the home also received an induction relevant to the role they were due to undertake.
● Staff told us they felt supported although they did not receive formal individual supervision with a member of the management team.
● The registered manager told us they did not undertake individual supervision of staff however, they always made themselves available should staff wish to discuss anything. Staff confirmed this saying they could, "Speak with [registered manager] or [provider's representative] whenever they wanted."

Supporting people to eat and drink enough to maintain a balanced diet
● Mealtimes were not always a positive experience for people. Where people required support to eat and drink this was not always provided in an appropriate way. For example, we observed one staff member using a spoon to get the person to open their mouth effectively forcing the spoon into the person's mouth.
● One staff member was supporting two people with their meals at the same time. We saw that when they stopped supporting one person the person stopped eating their meal.
● A person who had required full assistance to eat their meal had finished eating their meal and was falling asleep, but staff had given the person a beaker of tea after eating and walked off. The person fell asleep with the tea in their hand almost spilling it in their lap. Four staff walked past and did not provide support. A fifth staff member came over and took the beaker from the person's hand.

We recommend the provider review mealtime arrangements to ensure that this is always a positive experience for people and that they receive the support required in an unrushed, caring and dignified way.

● People were provided with a varied and nutritious diet and were provided with drinks and snacks throughout the day. Where people were at risk of poor nutrition and dehydration, plans were in place to monitor their needs. External professionals were involved where required, to support people and advise staff.
● Individual dietary requirements and people's likes and dislikes were recorded in their care plans and understood by kitchen staff. People were provided with a choice of two main meal options; however, they could request alternatives if required.
● Where required, people were provided with specialist cutlery to help them to eat their meal independently.

Adapting service, design, decoration to meet people's needs
● The layout, design, decoration or maintenance of the home was not suitable to meet the needs of all the people living there. A family member told us, "There is no quiet areas to get away from other residents who are vociferous both day and night."

● At the last two comprehensive inspections completed in August 2018 and July 2019 we recommended the provider seek advice and guidance from a reputable source about creating a stimulating environment for people who are living with dementia. At this inspection we found some improvements had been made but further work could be done.
● In 2019 we were shown an audit tool from Dementia Action UK which had been used to help the provider assess the environment. This detailed planned action including the use of contrasting colours in bathrooms. The main bathroom was on the ground floor and equipped with a shower. This room was in need of refurbishment and was also used to store equipment. It was not a relaxing or comfortable room and we noted staff kept entering the room to get items even when people were using the toilet. The positioning of the door and way it opened provided no privacy for people using the room.
● We were told there was a maintenance programme to help ensure the building remained fit for purpose, however we identified areas of the home which were not in a good state of repair. This meant these areas could not be adequately cleaned or presented a trip hazard for people, staff or visitors to the home.
● Constraints with the size and layout of the building presented some limitations regarding meeting the social needs of people. For example, armchairs in the lounge were arranged around the edge of the room with one behind a pillar. This limited social interaction between people at times. One side of the lounge was used as a walk through to enable staff to access offices located off this area and other parts of the home. People were sat in chairs with staff constantly walking past them throughout the day. Two televisions were in this area with no door to reduce the sound from one to other parts of the room. We noted that each television was turned to a different channel which would be confusing for people hearing a different programme to the one they could see.
● A conservatory was also available however; this was being used as a visiting room for family members meaning it was not available for people to spend time in. The dining area had insufficient room for all people to use if they wished to do so meaning many had their meals in the same lounge they spent the rest of their time sitting in.
● There was level access to a flat enclosed courtyard area which we were told people enjoyed using in warmer weather.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Care was not always provided in line with best practice standards, guidance or the law. Examples of care staff poor practice are included in other sections of this report covering moving and handling, MCA, communication and risk management.
● Assessments of people's needs were completed before people moved to the home. These identified people's needs and the choices they had made about the care and support they wished to receive. However, these were not always kept fully up to date as confirmed by the registered manager when we discussed risk assessments with them.
● Nationally recognised assessment tools such as Waterlow (a tool to assess the risk of skin breakdown) and Malnutrition Universal Screening Tool (MUST- a tool used to determine the risk of malnutrition) were in place and used to inform people's planned care.
● Each person had an oral care plan in place and guided staff to support people in accordance with the latest best practice guidance on oral care.
● People's protected characteristics under the Equalities Act 2010 were identified as part of their needs assessments. Their diverse needs were detailed in their care plans, including gender preferences for staff support.

Staff working with other agencies to provide consistent, effective, timely care
Supporting people to live healthier lives, access healthcare services and support
● People's health needs were documented in their care records. A family member told us, "The nursing care

is good and there is a friendly feel about the place."

● Where people required support from external healthcare professionals this was organised, and staff followed guidance provided. This was confirmed by information received from external health professionals. One external healthcare professional told us, "Although we only physically visit the home once every five weeks, the home is regularly in contact with our team and are very engaging and proactive in seeking advice when needed."

● Records confirmed regular access to GP's, practice nurses and other professionals such as the older person's mental health team, dentists and speech and language therapists.

● We observed staff seeking appropriate health support for people where this was required.

Inadequate

Is the service caring?

Our findings

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

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

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

- Observations did not always demonstrate people were treated with dignity and respect or in a kind and caring way. At the last two comprehensive inspections we found that staff's communication could improve, and we continued to find this for many of the staff members.
- For example, on three occasions we observed three care staff members support people to move using a hoist. A hoist is a mechanical device that is used in healthcare to transfer individuals from one place or position to another, when they are unable to do this independently. During these transfers none of the staff spoke to the person being supported, explain what was happening or provide any reassurance to them. On one occasion the person being moved showed signs of being scared and anxious and reached for a staff member's hand for reassurance. This staff member swiftly and forcefully pushed the person's hand away.
- We observed people being supported by staff to eat and drink. However, during this, staff did not speak or engage with the people they were supporting. For example, at lunchtime we observed a staff member supporting a person with their meal. The staff member was not communicating with the person at all and was just shovelling the spoon into the person's mouth.
- Just prior to lunch on day one of the inspection we witnessed a care staff member walk around the communal lounge and push lap tables over five people's laps. This was done without any warning and without communicating with people. No choice was given to people in relation to where they wished to have their meal.
- On several occasions on day one of the inspection we observed people attempting to engage with staff, however they were ignored, and staff walked away without any communication with them.
- We received mixed views from people about the care they received. One person said, "The staff that are here all the time are really good but being cared for by the other staff is humiliating, they treat me like I'm not here." Another person told us, "They [staff] are nice here." When asked if they felt care staff were able to understand people's needs and communicate with them a family member said, "There are a lot of agency staff currently and I do not believe this is as good."
- Throughout day one of the inspection, people were sat within the communal lounge of the home, with the television on. There was a large number of staff available to engage people in conversation and activities however, with the exception of two short occasions when a permanent staff member employed by the service helped a person with a puzzle and looked at pictures with another person, all other staff within the room took no action to converse with people.
- People's privacy was not always maintained.
- We observed staff entering rooms without knocking. Care staff described how they would maintain

people's dignity during personal care however, we did not always see this occurring. There was a bathroom near the main lounge which we saw people were supported to use throughout the inspection. However, other staff would open the closed door to get items from a cupboard in the room without waiting to ensure anyone using the facilities was suitably covered for their dignity. The door opened in such a way that anyone using the toilet could be easily seen from the corridor.
● Our observations of the lack of care provided to people were brought to the attention of the provider's representative and registered manager. The provider's representative told us they had identified this over the last few weeks and was in the process of arranging additional training for all staff including agency staff, in dignity and respect. The provider's representative also shared with us copies of emails they had sent to agency organisations they used sharing their concerns in relation to the staff's practices. However, the actions already taken had not resulted in improvements and people continued to be treated without dignity or consideration.

The registered person has failed to ensure people were treated with dignity and respect and ensure people's privacy, dignity and independence was maintained. This was a breach of regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Not all staff felt other staff were caring. For example, one staff member told us, "Most staff care about the people they support."
● On day two of the inspection we noted improvements in staff's communication, people were offered choices, spoken to nicely and engaged in activities.

Supporting people to express their views and be involved in making decisions about their care
● People were not always able to express their views or be involved in making decisions about their care. A family member told us, "The food is pretty standard and due to a lack of continuity between staff members individual requests can be overlooked."
● Throughout the inspection we observed multiple occasions when staff failed to communicate with people, seek consent or even tell them what they were planning to do. Specific examples have been described above and in other sections of the report.
● People's care records included information of how staff should involve people in making decisions about their care. However, during the inspection we found limited evidence people were supported to express their views and were involved in decisions about their care in practice. Where people were unable to express their views or make decisions their legal rights under the MCA were not consistently followed. This is discussed further in the effective section of this report.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has changed to requires improvement. This meant people's needs were not always met.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- On the first day of the inspection we observed very little engagement between staff or people. Most people were sat in the lounge with the television on although many seemed to be asleep or not watching the television. Staff in the area appeared to spend their time on laptops, mobile phones or using the handheld electronic devices that were used to access and record care.
- Staff actively ignored people who tried to gain their attention. For example, a person tried to get the attention of several staff members, who ignored them and walked straight past.
- People wanted to interact with staff. Whilst we were in the lounge area a person brought a jigsaw puzzle over and sat next to us. They were talking and playing with the jigsaw, communicating well and making eye contact. Prior to coming to us the person was sat staring at the wall with nobody communicating with them. Most staff did not engage in activities with people. Further examples are detailed in the caring section of this report.
- Where people were cared for in bed action to reduce social isolation and boredom was not always followed. In one person's bedroom we saw a sign saying, "Please turn on my TV." The person's television was not turned on and the person was in their bed staring at a wall.
- Whilst staff were assisting people they were talking to each other across the room and ignoring the people and their needs.
- On the first day of the inspection most people ate their lunch sat in the lounge with tables placed over their knees. They were sat around the walls of the lounge and therefore unable to engage with each other meaning the mealtime was not a social occasion.
- We spoke with a person in their bedroom. They told us they got lonely and they missed people. They added that there was one staff member who they had just started playing cards with but otherwise expressed feelings of isolation.

We recommend the provider seeks current guidance, reviews the arrangements in place to ensure people are always supported to avoid social isolation, follow interests and take part in activities that are socially and culturally relevant to them and update their practice.

- On the second day of the inspection more permanent care staff were on duty. We saw improvements with staff talking to people, playing cards with them and doing puzzles on a one to one basis. There was also an activity involving six people who were sat round a table with the activities co-ordinator making models with dough to later decorate. People were enjoying this and seemed really engaged. On the second day of the inspection people were sat at dining tables with staff members eating their meals. This was a very social experience.

● People's care records provided information about their social needs and what they enjoyed doing.
● An activities coordinator was employed. We saw on the first day of the inspection they had been assigned to provide 1-1 support for a person in their bedroom meaning they were unable to provide activities for the remaining people. They explained how they tailored activities to meet people's interests and needs but acknowledged this was not possible when they were allocated to provide 1-1 support away from the main lounge area.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
● People's needs were assessed prior to them moving to live at the home. Information from the initial assessments was used to develop care plans however, these were not always reviewed and revised as people's needs changed. Records of care provided confirmed that people were generally being supported in line with the information in their individual care plans.
● Information about people's life history as well as their likes, dislikes and preferences were recorded in their care plans. Staff had access to this information via an electronic system meaning they should have been able to understand people's needs, wishes and preferences in order to provide person centred care for people. However, as described elsewhere in this report we did not always see staff supporting people appropriately meaning people were not always receiving personalised care or have choice and control to meet their needs and preferences.
● It was not clear how people who were unable to communicate needs and wishes would have these met. For example, a staff member told us "People are given a choice to have showers – we will shower people when they ask."

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard [AIS]. The 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.

● As detailed in previous sections of this report we observed multiple occasions when people were ignored, or when staff failed to communicate with people.
● People's communication needs were identified, recorded and highlighted in their care plans. This should have helped ensure that staff were aware of the best way to talk with people and present information.
● The management team were aware of AIS and told us documents could be given to people in a variety of formats, for example, easy read, large print and pictorial.

Improving care quality in response to complaints or concerns
● The provider had a policy and arrangements in place to deal with complaints. They provided information on the action people could take if they were not satisfied with the service being provided.
● There were no open complaints at the time of inspection and records of historic complaints showed appropriate action had been taken to address the issues raised.

End of life care and support
● Care records viewed contained information about people's end of life wishes. For example, in one person's care plan there was clear information about their preference to remain at the nursing home unless it was absolutely necessary for them to be admitted to hospital.
● No-one was imminently approaching the end of their life at the time of this inspection. The registered

manager spoke positively about their desire to provide people with high quality care at the end of their lives, to help ensure they experienced a comfortable, dignified and pain free death. The registered manager had links with the nearby hospice and said they would always approach them for support when needed.

● Nursing staff had completed additional training to help them meet people's needs towards the end of their lives. This had included using equipment called syringe drivers which help provide regular pain relief. We saw that medicines to help manage symptoms had been obtained for some people meaning these could be commenced without delay should the need arise.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now 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.

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

- The service has been rated requires improvement since May 2015. During this time seven inspections of the service have occurred. Although some aspects of the service had improved at times, and some key questions had been rated good, this had not been consistently maintained and the service has failed to achieve an overall good rating. Caring and effective key questions have never been rated higher than requires improvement.
- The concerns we identified during this inspection in relation to staff training, risk management, medicines management, MCA, treating people with dignity and respect, had all been identified at various previous inspections.
- The most recent comprehensive inspection in July 2019 identified similar concerns to those we found at this inspection. Recommendations were made. However, we have not found evidence that necessary improvements have been made or sustained.
- The previous focused inspection in September 2020 identified concerns with the management of topical creams and care records. These concerns were continuing at this inspection.
- At this inspection we have identified breaches in relation to risk assessment and management, medicines management, infection prevention and control, staff training, consent, treating people with dignity and respect and quality assurance.
- Throughout this report we have identified areas for improvement. Quality monitoring systems were either not in place or robust enough to ensure people received a safe service. We could not be assured that management team understood the principles of good quality assurance or have the necessary skills to bring about and sustain the necessary improvements required to achieve an overall good rating and ensure people receive a safe, effective and caring service.
- The provider's systems and processes to assess, monitor and improve the quality and safety of the service were not effective and had failed to pick up all the issues we identified during our inspection. For example, care plan and risk assessments audits failed to identify conflicting information. Infection control and environmental audits had failed to identify all the concerns found in these areas during the inspection. Environmental audits had not identified the significant fire safety concerns we found and which we reported to the local fire safety team. Although fire detection systems had been checked weekly no fire drills had been undertaken since February 2021.

The failure to ensure processes are in place to assess, monitor and improve quality and safety is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The management team were responsive to our feedback during the inspection and appeared committed to making the necessary improvements. Where we identified areas for improvement on day 1 of the inspection, we saw actions had commenced to make some of the necessary improvements when we returned two days later. However, we were not assured that these improvements would have been made had we not undertaken this inspection.
● CQC were notified of all significant events that occurred in the service and the previous performance rating was prominently displayed on the premises as per requirements.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● This report identifies areas in which people did not receive a positive person-centred service. The caring section details multiple examples of when staff failed to communicate with people or treat them in a valuing person-centred way. People were ignored which would have a negative impact on their mental wellbeing and we saw others become distressed when staff failed to communicate with them when using moving and handling equipment.
● People were not always shown dignity or respect. We observed an undignified culture in the service where care staff were task focused and had little interaction with people.
● People were not empowered because there was a lack of understanding of the MCA process and staff did not always offer choices or inform people of what they planned or were doing where this directly affected the person. You can read more about this in the effective and caring sections of this report.
● Some staff felt the service was not a good place to work. When asked if they would recommend the service as a good place to work a staff member told us, "Not at the moment due to the amount of agency staff." Nursing staff said the high use of agency care staff, "Can present a lot of problems as agency staff need a lot of monitoring and we need to keep a close eye on their work."
● However, family members told us they were happy with the care provided. Comments included, "The manager and staff keep us informed of any concerns about our mother and we have been witness to the very best caution in visits during the COVID -19 epidemic."
● There was positive feedback from family members and staff about the registered manager who they felt was approachable and acted when specific concerns were brought to their attention. A staff member said, "I could go to [registered] manager if any issues and they would act." A family member told us, "I don't have any issues, but I could go to the manager if I needed to." Another family member said, "We did have concerns at the start of his stay as he made allegations of abuse that at the time we were really upset by. I have to say our concerns were addressed immediately and an investigation logged."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics. Working in partnership with others
● The provider told us they had recently completed a survey of people, family members and professional views about the service. They told us any issues with returned surveys had been individually addressed.
● Family members told us they were regularly kept up to date about their relative.
● The service worked in collaboration with all relevant agencies, including health and social care professionals. The registered manager and nurses were clear about who and how they could access support from should they require this. They demonstrated an open attitude to seeking support.
● An external health professional told us they were contacted appropriately by the home who followed suggested guidance and recommendations.
● The registered manager was also a member of a local care provider's forum that shared best practice guidance and belonged to a network of homes that focused on local healthcare issues.

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

● There were processes in place to help ensure that if people came to harm, relevant people would be informed, in line with the duty of candour requirements. We saw evidence these processes were being followed. However, the failure to ensure people were always treated well and their privacy and dignity maintained meant notifiable incidents under the duty of candour may not be followed up correctly.

● A family member told us they were promptly informed when their relative had suffered an injury and had been advised about the circumstances of the incident. They were happy that appropriate action had been taken.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered person has failed to ensure people were treated with dignity and respect and ensure people's privacy, dignity and independence was maintained. Regulation 10 (1)(2)(a)

The enforcement action we took:

cancellation or provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider has failure to ensure the Mental Capacity Act 2005 and associated code of practice is followed on all occasions where a person lacks mental capacity to make an informed decision. Regulation 11(1)

The enforcement action we took:

cancellation of provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider has placed people at risk due to a failure to ensure the safe management of medicines, that infection and prevention control measures were effectively managed and a failure to ensure risks to people and environmental risks were effectively managed. Regulation 12 (1)(2)(a)(b)(g)(h)

The enforcement action we took:

cancellation of provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider has failed to ensure processes are in place to assess, monitor and improve quality and safety of the service. Regulation 17(1)(2)(a)(b)(c)

The enforcement action we took:

cancellation of provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider has failed to ensure all staff have the necessary training, knowledge and skills to safely meet people's needs. regulation 18 (1)(2)(a)

The enforcement action we took:

cancellation of provider's registration