Indigo Care Services Limited

Island Court

Inspection report

Bourne Street
Woodsetton
Dudley
WV14 9HN

Tel: 01902886300

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20 June 2019

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Island Court is a residential care home providing personal and nursing care to older people and people with dementia. The accommodation is purpose built over two floors with the ground floor providing nursing care and the first floor providing personal care. The service can support up to 55 people. At the time of this inspection there were 46 people receiving support.

People's experience of using this service and what we found
People were not effectively safeguarded from abuse. Allegations of abuse were not always investigated or referred to external agencies. Risks to people were not always well managed and the provider did not always put people's safety first. This left people at risk of ongoing harm. People did not always receive their medicines as prescribed. A shortage of personal protective equipment impacted on the effectiveness of infection control. There were insufficient staff to meet people's needs. People's individual needs had not always been met with the right numbers of staff with the required competencies and skills.

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 mental capacity legislation was not always followed. There was not an effective system to monitor the status of deprivation of liberty authorisations, (DoLS), Staff were not always gaining people's consent to their care.

Some people's nutrition and hydration needs had not been fully assessed and met. People were not always supported and encouraged to eat to maintain a healthy weight.

People were not always supported by staff that were caring. People were not always treated with dignity or afforded privacy. The provider's staffing levels did not provide time for staff to display their caring values.

Some people spent long periods of time in their bedrooms. Activities were not personalised to individuals, where they were not able to take part in group activities.

The service was not well led. There was not a registered manager. The systems and processes in place identified areas for improvement. An action plan was in place to monitor improvement activity. This process had not always resulted in the required improvements being made and progress was slow. This meant that risks to people's safety or incidents that left people at risk of harm were not acted upon by the provider. People's and staff concern about the service had not been acted upon.

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 (Published 28 April 2017).

Why we inspected
This inspection was prompted in part by notification of a specific incident. This incident is currently subject to an investigation. As a result, this inspection did not examine the circumstances of the incident.

The information the CQC received about the incident, indicated concerns about the management of risk to people's health and safety and administration of medication. This inspection examined those risks.

We have found evidence that the provider needs to make improvements.

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

Enforcement
We have identified breaches in relation to keeping people safe, responding to allegations of abuse, numbers of suitable staff to support people to stay safe and meet their needs and good governance.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not effective.

Details are in our effective findings below.

Inadequate

Is the service caring?

The service was not 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

Island Court

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The first day of inspection took place on 05 June 2019. The inspection team consisted of one inspector, one assistant inspector, a Specialist Advisor who was a registered nurse and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The second day of inspection took place on 06 June 2019 when the inspection team consisted of an inspector and an assistant inspector.

A third day of inspection took place 20 June 2019 when the inspection team consisted of an inspector and a medicines inspector.

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

The service is required to have a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. At the time of this inspection there was not a registered manager.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed the information we had received about the service since the last inspection. We sought feedback from the local authority and external professionals that work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection-
We spoke with nine people who used the service and five relatives of people who use the service, we also spoke with the manager, the improvement manager, the improvement director, operations manager as well as two nurses, two care assistants, two senior care assistants, activities coordinator and staff from the housekeeping and kitchen teams. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included 12 people's care records and multiple medication records. We looked at five staff files in relation to recruitment, training and supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After in inspection
We continued to seek clarification from the provider to validate evidence found. We looked at nutrition and hydration information and quality assurance records. We spoke to professionals from the funding authorities who had visited the service to gain their feedback on whether people were safe and well.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant that people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

● People had not been safeguarded from alleged abuse. Where the service had received serious allegations of abuse against people and been provided with evidence, appropriate and effective action had not been taken to protect people whilst the matter was investigated. Following this inspection, the improvement director reassessed the risk to people and took appropriate action to protect people from further risk of harm.

● Staff confirmed they had received safeguarding training; however, this training was not put into practice. We saw in records that staff had witnessed people being placed at risk of harm and not reported this to the manager or used the whistleblowing policy and procedures to protect people from harm. An example of this is where a person was shouted at by a staff member, in the presence of another staff member. This incident had not been reported to ensure the person's safety.

Assessing risk, safety monitoring and management

●Risk assessments lacked robust detail about risks to people and how these should be managed. We viewed a diabetic risk assessment. This gave information about Ketone levels and at what level a coma or death could occur but did not inform staff of what actions to take in the event of raised ketone levels. The provider told us new risk assessments had been implemented. We reviewed two of these however they still did not inform staff of what actions to take in the event of raised Ketone levels.

Using Medicines Safely

● Medication administration records (MARs) viewed indicated people had not received their medicines as prescribed. There were occasions when people had not received their medicines, received the wrong dose of medicine or received their medicines at the wrong time. This caused people to experience unmanaged symptoms including pain.

● Medication records were not always clearly documented, and some entries were changed making them illegible. This meant the provider could not be sure medications were being received in a safe way or as prescribed as records were not clear.

● Staff did not follow the manufacturers guidance in administering the medicines. The application site of pain relief skin patches was not correctly rotated around the body. This could lead to skin irritation, affect the absorption rate of the medicine and cause breakthrough pain.

●As and when required medicines did not always have a protocol and where protocols were provided they did not always set out at what point the medicines should be administered. This meant that people were at risk of not receiving the maximum benefit from their medicines.

●Medicines were not safely stored. We examined the fridge temperature records, we saw that temperatures were not always recorded. The medication items in the fridge had been exposed to an incorrect temperature

from 01 April to 19 June 2019. Poor storage conditions could affect the medicines stability and as a result alter its effectiveness in treating the condition it had been prescribed for. We also found the treatment room door, on the first floor, had a broken lock. Staff had reported this to the improvement manager, but it had not been repaired in a timely way.

Preventing and controlling infection

●Staff were not supplied with sufficient supplies of protective gloves in the required sizes. We saw staff searching for medium and large sized gloves. A staff member told us, "We are given a budget, if the order costs more we have to choose what to go without". The improvement director told us that this was not the process to be followed, the orders should be passed to them to approve, if it was exceeding the budget.

●Planned cleaning was not completed. We looked at records of cleaning schedules and saw that these were not being fully completed by staff. We noticed a malodour in the corridor on the first floor and also in some areas of the ground floor. A Nurse told us, "I have two agency staff on with me, I haven't got time to tell them what to do, we are supposed to do the cleaning overnight, we don't do it as there is not enough of us". We saw the records showed that the overnight cleaning in that unit had not been recorded since 02 June 2019. This places people at risk from infection.

●There was a shortage of clean bed linen. On each of our inspection days we saw that only one of the two washing machines was serviceable. We read minutes of a staff meeting which took place on 29 April 2019, where staff had raised the shortage of clean bed linen with the manager. A staff member told us, "Staff that have left, threw all of the new sheets and towels away before they went leaving us with only the old ones". This meant that clean sheets may not be available at the point of need.

Learning lessons when things go wrong

● The manager had started a `lessons learned process`. We found that this process was not effective and failed to keep people safe, as lessons learned were not always shared with all staff. One staff member told us, "We are involved in lessons learned, we have a flash meeting, it would be good if we had a copy of this or they could leave it in the office or staff room, they don't do this currently". The manager could not produce an overview of the issues or outcomes of the process.

The failure to prevent people from receiving unsafe care and treatment and prevent avoidable risks of harm is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Staffing and recruitment

●People told us there were not enough staff to meet their needs. One person told us, "There aren't enough staff, they don't come quickly when you press the buzzer, you have to wait a long time, they are so busy and you think they are never going to come". Other people told us, "This is a big place there aren't enough staff, they're coming and going and have reached their limit" and "So many staff have left, they put too much work on them".

●Staff told us there were not enough of them to meet people's needs. They told us "More staff are required to provide extra bits of care", "We need more staff to be able to engage with residents outside of care delivery", and "We need more staff to ensure safety of the residents".

● We looked at the minutes of a staff meeting that took place on 15 May 2019. At this meeting the manager acknowledged that the day team were, "Struggling to meet the care needs of the residents" and recommended that the night staff support with breakfast. However, we saw from the rotas there were insufficient night staff to achieve this.

●The manager showed us their dependency tool, this had been incorrectly calculated and additionally was showing 11 hours per day understaffing. This meant that there were not enough staff hours to meet people's needs.

●The manager was constantly recruiting, however staff were joining and then leaving meaning there was an over-reliance on the use of agency staff. The rotas the provider gave to us showed that in the two-week period between 20 May 2019 and 2 June 2019, 67 shifts were covered by agency staffing.

● Even when utilising agency staff there was still a shortage of staff. The Improvement Director told us that four staff were required on the night shift. The night shift rota showed that on three occasions in 10 days, four staff had not been made available for people. On one occasion three care staff and the senior carer had all been covered by agency staff, meaning that one floor was staffed totally by agency. This staff level and skills mix placed Service Users at potential risk of harm.

Failure to provide sufficient numbers of suitably qualified, competent, skilled and experienced staff was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. 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 Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

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

● Not everyone that met the criteria for DoLS had current authorisations in place, which meant they were unlawfully deprived of their liberty. One person's DoLS had expired on 14 January 2019. The providers system for alerting renewal dates was ineffective. The regional director agreed to review all of the records.
● Not all staff were aware of which people had a DoLS in place. One staff member told us, "I think [name of person] has one, I'm not 100% sure". This could lead to conditions of authorisations not being followed by staff.
● We saw that staff did not always seek consent from people prior to delivering care or treatment. We saw one staff member administering medicines. They entered a person's room without knocking and did not explain what they were ding, instead they left the persons medication with their visitor and left the room again.

Failure to work within the Mental Capacity Act 2005 was a breach of Regulation 11 of the Mental Capacity Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
●The needs for some people had recently increased. One staff member told us, "Residents have recently presented with heart failure, a variety of infections resulting in increased confusion and one resident with a catheter". Staff had not been offered additional assistance or training to develop the skills to meet the additional needs and dependencies. This meant that staff were supporting people with care needs that they

had not received any training in.
● Staff received induction training prior to supporting people. Training records confirmed this and staff told us about the training they had received. Staff told us, "I'd like to do dementia training, but need in house training", "There is lots of training", and "All `e learning`, training is good it is useful, keep your mind focused, I am always learning new stuff."
● Staff did not always receive regular supervision. We looked at two records, both showed a one-year gap between the most recent and previous supervision. One record showed the most recent appraisal to be two years ago.
●. Staff administering medicines were not receiving regular practice supervision. This lack of supervision meant that staff did not have the opportunity to discuss their practice and the provider could not be assured that practice was safe and effective.
●People regularly saw staff that they did not know and who did not know their individual needs. One person told us, "At the moment there are a lot of agency staff. They don't know you very well and staff don't have the time to explain to them what needs to be done". And another said "New ones [staff] ask me what needs to be done, they ask me what cream they should use, but I am reluctant to tell them because I might tell them the wrong thing, so I am very careful about what I say".

Failure to provide sufficient staff with appropriate knowledge, support, training, supervision and appraisal was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● People had mixed views about the quality and choice of food. One person told us, "The food is rubbish I wouldn't give it to my dog". Other people told us, "They had sausages twice on the menu on Monday and you have sausages again today, and they know I don't like sausages", and one person told us "The food is very good".
● A Nurse told us there were insufficient numbers of staff to ensure people's dietary needs were met, they told us, "I would like adequate staffing to support meal times and to ensure the residents receive good nutritional care". We saw that after people were seated at the table people they had to wait for 35 minutes before their meals were served. We could see that people were getting restless. The dining experience appeared dull with people sitting in silence. We noticed that portions were small and when the plates were taken away, no one was asked if they would like more.
●During this inspection we did not see any snack, fresh fruit or drinks stations.
●Some people were served their meals in their rooms. We saw one person sleeping in bed with their meal left on the overbed table. We saw that a care assistant entered the room, woke the person and asked if they wanted their meal. They indicated no and it was removed. The person was not encouraged or assisted to eat. We saw their care plan that stated they needed encouragement to eat. We saw their weight records and saw they had experienced weight loss and were receiving food supplements.
● We saw an entry dated 31 May 2019 that three people needed to be referred to the dietitian due to weight loss. On 20 June 2019 we saw that these referrals had not been made. This placed these people at ongoing risk of weight further weight loss.

Failure to support people to have enough to eat and drink to meet their nutrition and hydration needs was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
● We saw that some facilities in the home were in need of maintenance and repair. We asked staff for their views on the facilities. One staff member told us, "Tidy the place up and get all the outstanding maintenance

jobs finished". Another staff member told us, "A maintenance man used to be based on site so repair jobs were completed quickly, now there is a maintenance book, as the man is no longer on site, this results in jobs not being completed in a timely way".

● We saw that the garden was in a state of disrepair and was not safe for people to use. A staff member told us, "I am not sure when the gardener should be working here, but it is a `hop and a catch` as to whether he is here or not". Another staff member told us staff and visitors were fund raising money for the garden. The improvement director confirmed the garden was not currently in use and told us that the repairs were in the long-term improvement plan.

● The ground floor bedrooms and lounge had been redecorated. The walls in the lounge had been painted magnolia and left bare. The improvement director said that new pictures and wall art were due to be purchased. The manager could not produce any evidence that people, relatives or staff had been consulted in the colour scheme or redecoration of the lounge. One staff member told us, "We need more soft furnishings to make Island Court homelier and more colourful as everything is magnolia".

● We saw that a toilet on the ground floor and the bathroom on the first floor was out of service. The improvement director told us that the bathroom was part of the improvement plan and did not know when it was due to be refurbished. This potentially left people with insufficient toilet and bathing facilities.

● The environment in the upstairs unit was not dementia friendly. Contrasting colours were not used to assist people to find bathroom, toilets or light switches. Signage was limited and not dementia friendly. This may affect the independent navigation of the home for people living with dementia.

Failure to properly maintain facilities and amenities was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Assessments of people's needs had been completed prior to them moving into the home. However, these assessments had not always identified the level of support required. Assessments did not always fully consider people's life history, risks to their safety or current needs.

● Some people's continence needs had not been assessed. We looked at the minutes of a staff meeting that took place on 15 May 2019. Staff at this meeting identified that, "Not all residents are assessed, and staff and relatives are taking other people's pads". We saw evidence that people who were continent were being placed into pads instead of being taken to the toilet. The improvement director agreed to update people's continence assessments and investigate the use of continence pads where this was not an assessed care need.

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

● Staff employed by the provider and staff supplied by the agency did not always work effectively together to meet people's needs. The manager did not integrate employed and agency staff to work together. Agency staff did not have the benefit of employed staff sharing knowledge of people's needs. This meant agency staff may not have been effective as quickly as they could have been as information about people's care needs had not been shared with them.

● Staff did not contact health care professionals for advice, where people had full capacity and were placing themselves at risk of harm. Instead staff dealt with the ill health effects this caused and did not seek advice. This placed people at risk of harm. Records show that one person had decided not to follow a diet put in place as part of diabetes management. This person then experienced diabetic symptoms and an ambulance response was required. There was no evidence that the provider had discussed this with the person or that the person understood the possible consequences of their decisions.

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 the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- People gave mixed feedback when asked about whether people treated them well. People told us, "Most do but they are always in a rush you feel they don't have the time", "There is a difference in attitude between the older and younger staff", and "I noticed that one carer was on their mobile phone all the time, even when sitting next to residents". One person told us, "They are lovely. You just have to ask, and they will bring it for you".
- Not all staff were caring in their approach to people. The staffing levels, systems and processes implemented by the provider had not always supported staff to display their caring values. We saw that staffing levels meant that staff were not able to spend time with people to promote their wellbeing. This was confirmed by a staff member who told us, "I would like to have more time to spend with the residents, I am too busy I should have time to sit with them". A visitor told us, "They are very caring, except when they are overworked".
- We saw that people's ethnic and cultural needs were not considered with activity planning. There is a new activities co-ordinator who told us, "I have not yet looked at different people's cultural or ethnic needs, I haven't really had time yet, I think I could do with help, it would be good to have more activity hours". The improvement director told us that interviews were being held to recruit an additional activities assistant.

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

- People did not always feel involved in decisions about their care. One person wanted to go out and thought they were not allowed to. This was brought to the attention of the manager who agreed to contact a relative and arrange for them to go out.

Respecting and promoting people's privacy, dignity and independence

- People were not consistently treated with dignity and people gave us mixed feedback. People told us, "More or less, they always shut the door. However, at one time I was on the toilet and a young carer stood outside with the door ajar and I had to tell them I would let them know when I had finished" and "They are very good, personal needs are attended to by the same gender carer and when not, they know what is allowed and what is not. The male carer applying cream to my legs will always say `Excuse me`."
- We saw in records that people's privacy, dignity and independence was not always promoted. One person had asked for assistance to go to the toilet, staff had refused to assist and applied a continence pad. This person was continent and mobile with assistance.
- We saw that people who remained in bed, were left with their doors open. Consent to leave doors open was not recorded in care plans. Other people were seen to be peering into rooms when passing.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● People we spoke to were not always aware of the care planning, assessment or review processes. This meant that they were not involved in the decisions about their care and did not have the opportunity to discuss their choices and preferences.

●One person told us that their care plan was up to date. They told us, "It seems that you have to speak up to get things done". This person indicated that they also spoke up for others.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● We were not presented with any evidence of the service following the AIS standards. We saw on the first floor, directional signage, to aid independence was not suitable for people with a memory impairment.

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

● We saw that there was a pictorial information board setting out when activities would take place. People told us that activities were provided such as darts, cards, board games and dominos. People told us that they mostly watched TV. One person said, "There is nothing to do, I watch TV". Another person told us there was a new activities coordinator, we were told, "They told us about the things they are planning, singers are coming next week, a summer fete is being organised and a seaside day with a collapsible pool, sand pit and puppet show".

● The activities co-ordinator told us, "I plan the activities with the people that live here. I have got a book and am completing a book about things people like to do". We could see that the activities coordinator was beginning to develop personalised activities, for example one resident is now bird watching and marking off different types of birds on a picture chart.

● Some people appeared to be isolated in their rooms and it was not clear in care plans why people were remaining in bed or in their rooms. One person was asked if they wanted to remain in their room, they told us, "Not particularly but I can't walk".

● A new hairdresser had started at the home. We could see that people's hair had been styled and that residents were talking with each other about their new hair cuts and how they liked them.

Improving care quality in response to complaints or concerns

● People and relatives had raised concerns with the manager. We saw in the records that the manager met with these people and their relatives and listened to their concerns. Some of the concerns were about the practice of agency staff. Where this was the case the complaint was passed to the agency. We noted that the manager did not get feedback from the agency and therefore was not able to complete feedback to people and relatives that had complained or use the outcomes of the investigation to improve quality of care and support.

End of life care and support

● Care records showed that people had been asked about end of life care and where they had made their wishes known these were recorded in the care plan.

● Staff informed us that people living in the upstairs unit were moved to the downstairs unit at the point they needed end of life care. Staff told us, "End of life care people generally move downstairs, so nurse can give end of life medicines, otherwise they would have to wait for the district nurse, the nurses had said they would loose their registration as it was residential on the first floor, I don't know if this is an excuse". We spoke to the improvement director about this and she said that this should not be happening and would investigate.

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 deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

● There was a temporary manager at the service who was not registered with the Care Quality Commission (CQC). The previous registered manager left in March 2018. During the inspection the improvement director informed us that they had recruited a new manager, but this person had advised them that they would not be taking up the post. Arrangements were in place to interview further candidates.

● Managers were not clear about their roles and did not demonstrate an understanding of quality performance, risks or regulatory requirements. For example, the manager did not have a good understanding of when to refer events to the local authority or CQC.

●Nurses did not effectively communicate with or update the manager about decisions they took that affected the overall risk of the home.

●Staff did not use the whistleblowing policy when other communication, about risk, had failed.

●The manager did not have an effective overview of the service. We could see that the manager identified concerns, recorded them on an action plan and took action to improve the service, however these actions were ineffective.

● The providers quality assurance system provided senior management visits to support the manager and review the action plan. However, we saw the manager and improvement manager were not effectively using the action plan.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● The provider had not ensured a positive culture within the service that achieved good outcomes for people. We received mixed feedback from staff. Some Staff told us, "It would be nice to feel valued and receive positive feedback", "The company does not appear to value their staff" and "[name of manager] could change their attitude, [name of manager] shows favouritism to some staff". Other staff told us, "[name of two managers] are approachable and will try to do whatever you ask" and "Staff morale was up and down but overall it is better now".

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; Working in partnership with others

●The provider had not fully acted on their duty of candour. Where things had gone wrong, investigations were carried out, but these were not always properly completed. The manager did not work in partnership with the staff agency. The manager did not receive information from the agency regarding the outcome of

the investigations carried out, for example the root cause analysis. This meant that people and their relatives were not given full information and the provider could not take effective preventative action.
●We saw from the minutes of a meeting between the nurse agency and the provider, dated 12 June 2019. The agency stated they did not always get sufficient information from the provider, to enable them to carry out reflective practice with their staff or properly investigate issues raised. This failure to work in partnership with the agency, negatively impacted on the managers ability to understand or manage risks within the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People and their relatives told us that residents' meetings were held regularly. During this inspection we requested information about how the manager sought people's ideas and suggestions, but this was not presented.
● Regular staff meetings were held but issues raised were not acted upon.
● Daily flash meetings were held with nurses' senior carers, kitchen staff and housekeeping. Issues raised in the meeting did not always get added to the quality assurance action plan. Staff were aware of the action plan, but it had not been fully shared with them and they did not feel included in the improvement plan. One person told us, "The manager should print the action plan and share it with the staff, so we know".
●The providers quality assurance systems and clinical governance meetings were not effective, as they did not identify and resolve issues that we found during this inspection. These included issues with risk assessments, medication, staffing, infection control, weight loss and continence. This also included issues with the staff culture, and overall communication, for example duty of candour, working in partnership with others and acting on information received to keep people safe.

The failure to operate effective systems and processes to monitor and improve the quality of the service is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 11 HSCA RA Regulations 2014 Need for consent You did not always work within Mental Capacity Act 2005 or seek people's consent for care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Failure to support people to have enough to eat and drink to meet their nutrition and hydration needs and did not always refer people promptly, to a dietitian, when they lost weight.

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 You railed to properly maintain internal facilities and amenities and the garden was unsafe for use. Signage was not suitable to aid the independence or orientation of people with dementia.

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 You failed to provide sufficient numbers of suitably qualified, competent, skilled and experienced staff, with appropriate knowledge, support, training, supervision and appraisal to meet people's needs.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	You did not protect people from unsafe care and treatment avoidable or risks of harm. Safeguarding policies and procedures were not followed, you did not effectively assess monitor of manage risk, people did not always receive their medicines as prescribed, infection was not effectively controlled and lessons were not learns when things went wrong.

The enforcement action we took:

Notice of Proposal.