# 3A Care (London) Limited

# Amberside

## Inspection report

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## Ratings

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| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

What life is like for people using this service:

The service was newly registered in October 2017, and began admitting people in February 2018 following refurbishment works. The service had a registered manager in post and a deputy manager.

Staffing levels did not consider the needs of people living with dementia, mental health or with complex care needs. People had to wait for key areas of support such as meals, drinks and personal care, along with not receiving appropriate support with their behaviour which challenged others. The manager and deputy worked along side staff and had no time to ensure that the overall care people received was safe. This led to a lack of monitoring of people's hydration, nutrition and pressure area care monitoring. On the first day of our inspection we discussed our findings with the provider. They immediately took action and increased staffing levels accordingly.

People told us they did not always feel safe, and the registered manager had not reviewed people's needs when incidents occurred. Staff were aware of how to keep people safe from harm and when to report concerns. Staff were not able to review incidents openly to learn lessons when things went wrong. The provider undertook a guarantee to review their safeguarding practises and provide staff with additional training.

Staff were not trained to provide care effectively. The registered manager had not ensured staff received training in key areas such as pressure care, continence and dementia care. This impacted on staff awareness and ability to proactively and positively support people. The provider gave us assurances they would review their training program. On the second day we saw training had been booked and delivered in key areas such as pressure care and medicines management.

People's consent had not been obtained in line with the legal requirements necessary, particularly where people lacked the capacity to provide this consent. The process to assess a person's capacity was not followed and documented as required. The registered manager and deputy manager told us they were in the process of reviewing this.

People did not consistently receive care based upon their needs and preferences. Staff were aware of people's preferences and choices, however staffing levels did not allow this to be delivered. The additional pressures placed on staff meant they were not able to establish meaningful relationships with people. People told us they felt well cared for by staff who treated them with respect and dignity. People were not always provided with range of activities or social inclusion and told us they felt bored at times. On the second day of the inspection we saw increased staffing had a positive effect with staff having more time to spend with people.

We were not confident the registered manager and provider understood their role in engaging with the

whole staff team to listen and support them to improve. The registered manager completed some audits and checks of the safety and care in the service. However, these did not identify the issues raised at this inspection, for example with staffing levels, training and personalised care. The provider did not monitor the quality of care in the service. Records we looked at did not always reflect the support provided to people, or rationale for decisions made. We discussed this with the provider who agreed they needed to develop systems to monitor the service closely.

More information is in Detailed Findings below

Rating at this inspection: Inadequate

The overall rating for this service is 'Inadequate' and the service has been placed in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to further urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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

Following the inspection CQC reviewed the concerns and took appropriate urgent action to immediately restrict admissions to the service. This was to keep people safe from the risk of harm.

About the service: Amberside is a residential care home that provides personal care for up to 21 people some of whom are living with dementia. At the time of the inspection 14 people lived in the service. The service had admitted some people who they were not able to care for and who were not included within their registration.

Why we inspected: This was a planned comprehensive inspection to provide a rating for the service. Concerns had been raised with CQC in relation to medicines management and safeguarding concerns. This is the first time Amberside has received a rating from CQC.

Follow up: We will meet with the provider following this report being published to discuss how they will make changes to ensure the provider improves the rating of the service to at least Good. We have referred our findings to the local authority health and social care teams, along with the fire service who will also monitor the quality and safety of care provided. We will revisit the service in the future to check if improvements have been made.

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

We always ask the following five questions of services.

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

# Amberside

**Detailed findings**

## Background to this inspection

The inspection: We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team: Two inspectors visited the service on 05 December 2018. One inspector visited the service on 11 December 2018 to ensure actions arising from the previous visit were complete.

Service and service type: Amberside is a care home. People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection: This inspection was unannounced.

What we did prior to this inspection and when we inspected the service.

We reviewed information we had received about the service since they first registered on 04 October 2017. This included details about incidents the provider must notify us about, such as abuse. We reviewed information received about concerns and complaints raised to us. We sought feedback from the local authority and professionals who work with the service.

During the inspection, we spoke with five people who used the service and two relatives to ask about their experience of the care provided. 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 spoke with eight members of staff including the registered manager, deputy manager, senior care workers and care workers.

We reviewed a range of records. This included six people's care records and associated medication records. We also looked at records relating to the management of the home including audits, training and supervision, infection control and health and safety.

Inadequate

# Is the service safe?

## Our findings

Safe – this means people were not protected from abuse and avoidable harm

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

Aspects of safety were not enough to protect people from avoidable harm

Assessing risk, safety monitoring and management.

- Assessments carried out by managers before admitting people in the home were not consistently carried out robustly. Three people were admitted into the home and assessed as having needs staff were not trained to safely meet. Subsequent to the inspection these people were considered having complex needs which could not be safely met at the home and they were referred to the local authority for a better placement.
- The environment was not safe. There were areas of flooring that were uneven and poorly laid presenting a trip hazard. Emergency plans were in place to evacuate people in an emergency. The provider had not taken action following a fire assessment in March 2018. This raised significant concerns regarding safety of people in case of a fire that remained at the time of this inspection. We referred our findings to the fire protection officer and local authority.
- People at risk of developing pressure ulcers did not have appropriate assessments in place to mitigate the risk. For example, one person had their assessment calculated incorrectly indicating a lower risk to develop pressure ulcers and this resulted in them not having the pressure relieving equipment needed. They had previously developed a pressure ulcer. Following the inspection a review was carried out by the provider and other people were identified who had skin integrity needs, but did not have either equipment in place to manage, or an appropriate referral made to healthcare professionals. One staff member said, "Resident`s skin has got worse because we didn't have the skills or training, and not enough staff. We couldn't get to give pressure care, repositioning, or get people up. We found it difficult to change people`s pads because of the [staffing] levels."
- Staff did not identify when people were at risk of deteriorating health. One person was observed to deteriorate over the day by inspectors. The registered manager was asked to seek emergency care for this person that resulted in hospitalisation. Staff did not identify or respond to this change in health.
- Staff did not respond effectively to people when they became distressed or shown signs of aggression to others. This was because there were not sufficient staff on shift who knew people well and assessments and care reviews did not describe how staff would support people consistently, and identify when a person was distressed. Permanent staff relied on discussion among themselves to manage this, but agency staff used were unaware. Action was taken by the provider to seek additional training, and additional staff were provided to support people.
- People`s nutritional needs were not safely managed to avoid harm. Records for blood glucose consistently demonstrating high levels were not responded to. A person was not provided an appropriate diet following professional advice. Their glucose level only stabilised when provided with emergency healthcare. People who experienced weight loss did not consistently receive an appropriate diet designed to promote weight gain. Records of food and drink given were not accurate. Staff were unaware of glass,

beaker sizes or portion sizes to accurately record the amount consumed and consistently recorded, "200ml," for example, when the amount drunk was significantly higher or lower.

Using medicines safely
•Medicines were safely stored but not always safely managed.
•People did not always receive their medicine as prescribed. We found people prescribed medicines, "To be given with or just after food," had this an hour after eating breakfast. People who refused medicines were not observed to swallow their medicine. Staff told us of numerous times where tablets were found on the floor half consumed. Although the registered manager was aware, no actions had arisen to review medicine administration, or to ensure staff safely observed people swallowing their tablets. •Guidance was not available to staff to direct them when to administer 'As required' medicines such as pain relief.
•Regular checks were carried out of the medicines stocks. We found that there were no errors or omissions in the medicines record, and stocks tallied.

The registered person had failed to ensure people's care was delivered in a safe manner ensuring known risks were identified and safely managed. This did not protect people from the risk of avoidable harm. This has been rated as 'Inadequate'.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safeguarding systems and processes
•Safeguarding systems were in place and staff spoken with had a good understanding of what to do to make sure people were protected from harm or abuse. One staff member said, "I would report abuse, neglect, things like bruising on somebody or if they are losing weight, even if they have dementia I take it seriously and report. I could go to social services, or CQC."

•Safeguarding incidents were not always reported. The incident records stopped in October 2018. However, the registered manager confirmed there had been incidents since that date, which they should have referred to the local authority, such as aggressive behaviour. People's care was not reviewed when they displayed aggression, and appropriate referrals were not made to health professionals. The provider told us they would review the incidents and report appropriately.
•People told us they didn't always feel safe. One person said, "I have been shouted at, poked and scared by [Person] it's quite frightening." A second person said, "Mostly I feel safe, but there are times when I don't, mostly when the staff are not around."
•A visiting professional told us, "Staff appear to now be more aware of how to report safeguarding issues and have raised issues promptly over recent months."

Learning lessons when things go wrong
•Staff were not aware of the outcome of safeguarding incidents that had been reviewed by the local authority. Staff told us they did not review incidents to review their practise, and discussions were not held formally or informally to learn lessons when things went wrong.
•Evidence was not available to show that when something had gone wrong the registered manager responded appropriately and used any incidents as a learning opportunity.
•Staff did not review risk assessments and care plans following incidents. The registered manager agreed to take action in future to address this.

People did not feel safe and incidents were not safely managed, reviewed or reported appropriately. Staff

did not review incidents as part of a formal process to learn lessons when things went wrong. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing levels
•The provider had not ensured enough staff were on shift so that people received support in a safe manner. People's continence needs were not met in a timely manner by staff. Staff were not present in communal areas to monitor people at risk of falls or who may become aggressive towards others.
•The provider did not regularly review people's changing needs to ensure sufficient staff numbers were available. Staffing levels did not match the needs of people living in the home as people's care requirements exceeded the care hours provided.

•Staff, people and their relatives did not all think staffing levels were safe. One staff member said, "Staffing levels were poor. They thought because they had fewer residents so they didn't need the staff all the time. We can't give the care short staffed. We have a variety of needs that until now we couldn't meet." We observed during the 1st day of inspection people being aggressive towards others, left at risk of falls whilst unsupervised, and a lack of interaction and monitoring by staff. The provider increased staffing by two carers during the day and one at night. On the second day of the inspection we saw people were responded to in a prompt manner.
•We saw all staff had been recruited safely by the provider. Where agency staff were used, the registered manager had ensured they had the necessary training to provide safe care. However, the registered manager could not provide when asked copies of verified references and training for one new staff member.

Preventing and controlling infection.
•There were no malodours present in the home. Staff were observed to keep the home tidy and clean. However, when we looked at the store when cleaning products and equipment was stored we saw this was not well stocked. On the second day of the inspection we saw a large delivery of cleaning equipment being delivered.
•Staff followed good infection control practices and used personal protective equipment (PPE) to help prevent the spread of healthcare related infections.
•Staff demonstrated a good understanding of keeping the home clean, and how to prevent the spread of infections.

Requires Improvement

# Is the service effective?

## Our findings

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

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

•Assessments of people's needs were not comprehensive.
•Assessments had not been done and expected outcomes were not regularly reviewed.
•Staff did not apply learning effectively in line with best practice. This meant that people experienced poor care and were not supported to enjoy a good quality of life.

Staff skills, knowledge and experience

•Staff were not all competent in their roles as they had not received the necessary training to support them carry out their roles effectively. Staff were not able to develop their skills or undertake areas of specialism such as in safeguarding, moving and handling or dementia care. This would enable staff to support other staff with achieving best practise in these areas. One staff member said, "We don't have the champions, but [Provider] talked to us in a meeting last week Friday about having champions. I would like to specialise and support my colleagues. It hasn't happened yet."
•Staff had not completed a comprehensive induction. Key areas of training for staff had not been provided. For example, managing pressure care, continence, mental health and supporting people with complex dementia. One staff member said, "Induction was where the fire exits are, the policy about complaints, residents who have allergies. Training was first aid, moving and handling, I was happy with the training. Safeguarding training was on a piece of paper, it was okay, I didn't learn much from it." This had led to poor outcomes for people.
Following this inspection, the provider and registered manager submitted an action plan that addressed the gaps in staff knowledge.
Staff had the opportunity for supervision and were positive about the support they received. One staff member said, "I can say what I feel and how I feel I can improve. I have asked for more training, and we now doing the care certificate because of this inspection. They [Managers] think it is a good idea I do the care certificate as I haven't had training for ages."

Staff had not been provided with adequate training, development and review of their skills and capabilities. Staff were not supported to develop their skills further to promote best practise when providing people with care. This was a breach of regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Eating, drinking, balanced diet

•Where people required their food to be prepared differently because of medical need this was not catered for. One person required assistance with diabetes. The professional guidance was not implemented and

they did not receive a diabetic diet. This led to fluctuating blood sugar levels. The chef did not have sufficient training to safely meet people's needs.
•People who ate a regular diet had choice and access to sufficient food and drink throughout the day; food was well presented and people appeared to enjoy it.
•People at risk of weight loss did not have their meals routinely and consistently fortified where required. Although people's weight was seen as stable, and some people had increased their weight, staff had not queried the accuracy of the weights taken. For example, one person had lost 4.2kg in one month. Staff did not consider whether the reading was accurate, and had not referred to a dietician as required.
•Assessment tools and care plans had not been robustly developed to manage people's nutritional needs effectively.
•Where people were at risk of poor nutrition and dehydration plans were not consistently in place to monitor their needs. Staff did not accurately record the amount of food or fluid consumed. Staff recorded for example that people drank 200ml's of water, when we reviewed with the registered manager we found this was incorrect.
•People's dining experience varied. Some people sat in the dining room to eat. Others were left in the lounge, having already been sat in one position for an extended period. The environment was not sociable or engaging. Staff did not prompt people to eat or drink, or offer further portions when they had finished.
•In the safe section of the report we explained that at times staffing levels were low. This impacted how staff were able to support people with their nutritional needs.

Healthcare support

•Where people required support from healthcare professionals this was arranged however staff did not always follow their guidance. People had information available to take with them to hospital that described their care needs, medicines, allergies etc.
•The GP regularly visited people in the home, and people told us they could see the relevant health professional when needed.
•Following this inspection, the provider assured us they had carried out a full review of people's needs. This had resulted in referrals to healthcare professionals, that prior to this inspection had not occurred. This included areas relating to tissue viability.

Adapting service, design, decoration to meet people's needs

•People were not involved in decisions about the premises or environment.
•The provider had recently carried out renovation works of the home. However, they had not considered the needs of people living there to ensure it was dementia friendly. People living with dementia were seen to find it difficult to orientate themselves around the building. The provider had not considered best practise in relation to supporting people with dementia such as reminiscence areas, lighting, decoration of path finding.
•The home had sufficient amenities such as bathrooms and communal areas.
•Technology and equipment was used effectively to meet people's care and support needs. For example, people used sensor mats to alert staff that they needed support and call bells systems alerted staff when support was required.

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 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. The application procedures for this in care homes and hospitals are 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 were being met.

•Staff did not ensure people were involved in decisions about their care.
•for example, consent had not been signed by the person. We saw from records people's relatives had signed to say the person was happy to receive intimate care, and that staff could share their information. People's relatives who had signed did not hold the legal authority to make these decisions. The process relating to assessing the persons capacity and best interest had not been applied when seeking consent.
•Where people did not have capacity to make decisions, they were not supported to have maximum choice and control of their lives. Staff did not always support them in the least restrictive way possible.
•Staff did not understand which decisions required an assessment of capacity. One staff member said, "[The assessments] are for normal living, such as joining the lounge, going to the dining room, food choices, drink choices. We are not making financial decisions or care decisions, they can do that."
•Where people were deprived of their liberty, the registered manager worked with the local authority to seek authorisation for this to ensure this was lawful. However, these were not consistently reviewed where required. One person had a DoLS assessment in place for seven days, which had since expired and not been renewed. However, the were still deprived of their liberty.
• We found examples where people were continuously monitored, for example use of sensor mats in their room. The appropriate capacity assessments had not been completed, least restrictive measures not used, and an application for DoLS when considered necessary had not been made.

People's consent had not been sought. This meant people's views and opinions had not been considered and the legal requirements of obtaining consent had not been met. This was a breach of regulation 11 of the Health and Social Care Act 2009 (Regulated Activities) Regulations 2014.

Requires Improvement

# Is the service caring?

## Our findings

Caring – this means that the service involved people and treated them with compassion, kindness, dignity and respect

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

●People told us they were not involved in making decisions relating to their care. People's assessments were completed with their relatives and not with them. When people's needs were reviewed they were not part of the discussion. One staff member said, "We have not had training, we were shown by the senior how to do it. We will look at her needs, how they have changed. We read through what was written originally and amend any changes. We should sit with the person and ask them but we haven't done it. We are doing it since the CQC came, but we haven't in the past."
●Assessments for two people showed they had not been asked about the choice of care home prior to moving in. One person moved in and was not given the opportunity to look around, meet people or staff. Their behaviour then became erratic and aggressive when they moved to the service. Their relative said, "There has been no discussion or consultation with me about where [Person] goes, they have just been brought here." A second person's relative had viewed images on the internet and considered that sufficient when determining the choice of care home for their relative.
●People were not provided with independent advice or support from services such as advocates. People had not been provided information referring to these services in a format they could understand.

Respecting and promoting people's privacy, dignity and independence.

●We observed that people's appearance varied. Some people were well groomed, clean and well presented. However, some other people we observed were not. For example, one person had a stain on their jumper. Staff did not help the person to change this for the duration of the inspection, even though it was shown to them. This person was later seen to be left in an undignified manner as staff did not address their personal care needs. Other examples were people's hair not groomed, people with staining to their clothing.
●Prior to this inspection, the lift unexpectedly broke down. One person was then left upstairs unable to get downstairs. They clearly wished to be able to spend time with other people, be as independent as they could be. However, for nearly one month this person was confined to their room. This did not promote their freedom, independence or dignity.
●People told us they could not be independent. They told us staff did not enable them to do things for themselves, such as washing themselves, helping to get dressed, or assist with household chores. One person said, "They just do what needs to be done, we don't get a say in what we can help with."
●People's confidential information regarding their care needs and personal information was not held securely. When we arrived at the home, we were freely able to walk around the home unchallenged, entering the office and reviewing people's record detailing intimate information about their needs. This did not ensure people's information was securely stored to protect their privacy and confidentiality.
●Staff when given sufficient time to spend with people were seen to be attentive, caring and showed

genuine concern. This had improved on the second day of our inspection due to the increase in staffing levels.

Ensuring people are well treated and supported

●People were not consistently treated well. Due to staffing issues, people were ignored and their preferences regarding their care were not met. One person was heard to say, "Just want to go home." Their hair was not brushed and were ignored for most of the day even though they were distressed. This person was repeatedly seen repetitively exercising their arms and humming.
●Staff had documented some people's preferences and life history, however not all staff were able to tell us what was important to people. We found that those people who required more support received more time from staff, but this was to the detriment of others who were marginalised.
●Comments from people regarding the staff approach varied. One person said, "They are exceptionally caring and well mannered, I have no complaints." A second person said, "We end up fending for ourselves, lucky for me I can do things but for those who can't it must be horrible."

People's independence and dignity was not promoted or met. People were not involved in decision relating to their care. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

# Is the service responsive?

## Our findings

Responsive – this means that services met people's needs

People's needs were not always met. Regulations may or may not have been met.

People did not receive personalised care that responded to their needs.

Personalised care

•Staff knew people's likes, and preferences. However, this was not consistently documented in people's care records or updated. Sufficient staff were not deployed to enable staff to spend time with people to ensure the care provided met their needs. One person said, "They can rush at times, not all of them but some so I end up with things I would prefer not to have."
•People were not empowered to make their own choices and did not have as much control and independence as possible, including in developing care, support and treatment plans.
•People's needs were not consistently identified, including those related to protected equality characteristics. For example, reasonable adjustments were not made to ensure the environment was dementia friendly.
•Staff had not had sufficient training to understand the needs of people living with dementia or mental health needs. The inability of the provider to ensure high quality care was provided to these people, meant they had experienced care that was not of a satisfactory quality.
•People had limited access to activities. The activity staff told us, "I Would love to do more with the residents but there is not enough staff. I end up undertaking care duties as there is not enough staff to do this. I am worried that residents never get the chance to go outside. I was upset as wanted [Person] to go out to see the Christmas lights but couldn't."
•The activities chart for our first day of inspection noted there were games and chair exercises planned. None of this happened on this day, and staff along with management confirmed that much more could be improved to ensure people's social and leisure needs were met.
•We observed two people sat outside the kitchen. The television was switched off, and both people were sat next to the kitchen door, enduring the loud, inappropriate music played by the Chef. When asked, both said they did not enjoy the music, but also told us they could not ask for it to be changed to something they may enjoy.
•People told us they felt bored at times. Comments received from people included, "I am bored for most of the day." "It's lonely with nothing to do or like minded people to talk to." "I sleep most of the day."

People's care had not been assessed, or reviewed collaboratively with them. People's care was not designed to meet their individual needs and preferences. People were not provided with opportunities to pursue social or leisure activities they may enjoy.

This was a breach of regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
•People told us they felt they could raise their concerns with staff, however felt they could not always approach the registered manager. One person said, "They [Registered Manager] would have to be here to make a complaint to, but I never see them."
•Complaints or concerns that were received by the registered manager were logged and reviewed. However, the outcomes of these were not shared or discussed to identify where lessons may be learned and could improve people's experience of care.
•The provider had recently reviewed the complaints raised formally, however they did not analyse these to understand themes and patterns. We discussed ways the provider could improve how they monitor complaints received

End of life care and support

•People were not receiving care or support for end of life care at the time of this inspection.
•Staff had not received training specific to this area to support people's needs when the time came.
•This is an area that the provider needs to improve to ensure that staff are provided with adequate training, support and guidance. The provider needs to improve their local links with organisations who can assist, support and guide staff, such as health professionals, local hospices and community organisations.

Inadequate

# Is the service well-led?

## Our findings

Well-Led –Service leadership, management and governance did not assure high-quality, person-centred care; supported learning and innovation.
Managers and staff were not clear about their roles, did not understand quality performance, risks and regulatory requirements

●The provider did not operate a formal quality assurance and governance system to monitor the quality of care provided. We asked if they reviewed the care, and whether they audited the home. They told us they did not. They told us they did not have a shared improvement plan, based upon identified areas that required improvement.
●The provider and registered manager were not aware that staff had not received training in key areas. Where we identified training required in areas such as pressure care, continence, dementia, they told us they had not realised this was an area needing improvement.
●Systems were not operated by the registered manager or the provider to monitor the quality of care. The registered manager did not have an overview of the training for staff, dependency levels of people to base staffing around, or an overview of the care needs for people.
●The registered manager did carry out some of their own audits, however these were not analysed and did not prompt improvement. The registered managers audit tool did not identify assessments for people were inaccurate, such as Waterlow, that care records were not updated when people's needs changed, and that assessments of capacity lacked sufficient detail.
●Areas for development we have noted such as staffing, record keeping, activities provision and training were not picked up by the providers audit process. They agreed to review their methods to ensure they captured such patterns going forward.
●Both the registered manager and provider had failed to act on actions required by a recent local authority review. This identified training, staffing and fire protection as areas that required review. When we inspected four months after this review, we found nothing had been done to address this. This left people at significant risk of harm in the event of a fire.
●Both the registered manager and provider told us that they had focused on increasing occupancy. This led to them knowingly admitting people to the service they could not provide adequate care for. Where they had then admitted people with complex dementia needs or mental health needs, they had not ensured their quality improvement systems identified how they could then safely care for them. This had led to these people both receiving less than satisfactory care, and them being moved to another establishment.
●The registered manager was aware that two staff used to provide care were not trained, and had requested one to provide care on the first day of our inspection.
●Staff told us that at weekends they were unable to contact management in an emergency. For example, staff told us they were recently short at the weekend. This resulted in an agency staff member contacting a staff member, who was not trained and asking them to provide caring duties.

Engaging and involving people using the service, the public and staff

●People and staff gave a mixed response in relation to the registered manager. One person said, "Manager, I

don't know who they are really there are a few of them." One staff member said, "The Manager is never here before 9.30 and never at weekends really." A second staff member said, "They [Registered manager and provider] are doing things because you [CQC] told them to. We have told them and they haven't improved things before now."

●People's feedback had been sought about the quality of care provided. As the responses had only been recently received the registered manager was reviewing the feedback at the time of the inspection.

•A culture of continuous learning was not embedded within the culture of staff or management which meant objectives were not focused on areas for improvement.

Working in partnership with others

●The service had not developed links with the local community and key organisations, reflecting the needs and preferences of people in its care. A local training and support organisation had been approached but not engaged with. The registered manager was not in touch with support organisations who could aid with providing quality care. Links had not been made with local community groups that would support people's inclusion within their local community.

The service provider failed to demonstrate that their systems identified and reduced the likelihood of avoidable harm. Therefore, the service is rated inadequate.

The lack of robust quality assurance meant people were at risk of receiving poor quality care and should a decline in standards occur, the provider's systems would not identify and respond to these issues effectively. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not informed CQC of changes to the types of care they were providing. We identified three people who had needs exceeding those approved at their registration including mental health. The provider had not updated their statement of purpose to demonstrate how they would safely meet these people's needs, and had not submitted this to CQC as required. This was a breach of regulation 12 of the Care Quality Commission Registrations Regulations.

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 | Regulation 12 Registration Regulations 2009 (Schedule 3) Statement of purpose<br><br>12 Statement of purpose (1) (2) (3) Schedule 3.<br><br>The registered person did not provide the Commission a statement of purpose containing the information listed in Schedule 3.<br>The statement of purpose was not kept under review and the Commission was not updated when changes to service user bands were effective.<br>The statement of purpose failed to address the kinds of services provided for the purposes of the carrying on of the regulated activity and the range of service users' needs which those services are intended to meet |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>Person centred care. Regulation 9 (1) (a) (b) (c) (2) (a) (b) (d) (e)<br><br>People's care did not meet their needs, preferences and was not appropriate to their individual needs.<br><br>An assessment of people's needs was not carried out collaboratively with them. People's care was not designed to ensure people were able to make, or participate in making, decisions relating to the their care to the maximum extent possible. |

| Regulated activity | Regulation |
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|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>Consent. Regulation 11 (1) (2) (3)<br><br>The registered person had not acted within the requirements of the Mental Capacity Act 2005 when obtaining consent for people unable to provide this. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Safe care and treatment. Regulation 12 (1) (2) (a) (b) (c) (d)<br><br>The risks to the health and safety of service users of receiving the care or treatment had not been robustly assessed. The registered person had not done all that was reasonably practicable to mitigate any such risks. Staff providing care or treatment to service users did not have the qualifications, competence, skills and experience to do so safely. The premises used by the service provider was not safe to use for their intended purpose. People's medicines were not managed safely. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>Safeguarding service users from abuse and improper treatment. Regulation 13 (1) (2) (3)<br><br>Systems and processes were established but not operated effectively to prevent abuse of service users.Systems and processes were established but not operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse. |

| Regulated activity | Regulation |
|---|---|

| | |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Good Governance. Regulation 17 (1) (2) (a) (b) (c) (3)<br><br>Systems were not implemented or operated effectively to ensure people received good care. Governance systems did not assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. People's care record were not accurately maintained.<br><br>The registered person did not maintain service improvement plans to improve the standard of the services provided to service users with a view to ensuring their health and welfare. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Staffing. Regulation 18 (1) (2) (a) (b)<br><br>Sufficient numbers of staff were not effectively deployed to meet people's needs safely. Staff had not been provided with sufficient training to support people effectively. Staff were unable to obtain further qualifications relevant to their role. |