HC-One Oval Limited

# River Court Care Home

## Inspection report

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Tel: 01923800178

Date of inspection visit:
18 June 2019

Date of publication:
08 October 2019

## Ratings

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|---|---|
| Overall rating for this service | Inadequate |

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|---|---|
| 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:
River Court provides accommodation, personal and nursing care to older people. The care home accommodates up to 120 people in a purpose-built building which was divided into four units. At the time of the inspection 115 people were living there.

People's experience of using this service:

People had their individual risks assessed but did not always receive care that promoted their welfare. For example, moving and handling where we observed that people were not always supported safely. Some people had unexplained bruises or skin tears that had not been reported to the local authority safeguarding team or investigated to establish the cause.

People told us that they received their medicines when needed. Medicines were managed safely.

People gave mixed views about whether care always met their individual needs and feedback from people about the service provided was mixed. 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 consistently support this practice. Complaints and feedback were managed in the home in accordance with their policy to give the provider an overview of the issues being raised by people and their relatives.

Records reviewed of people's weight indicated people were supported to eat and drink enough. There were management plans for people who were losing weight. However, the information readily available at meal service relating to dietary needs, modified consistencies and cultural needs needed to be more robust. The dining experience also needed improving.

The provider had systems in place to help them identify and resolve any issues in the home. For example, audits and action plans, which included involvement from the provider's quality team. However, these were not used always used effectively. We found the issues found at this inspection had not been identified by the providers quality monitoring.

Feedback about who the registered manager was varied throughout the home. People, relatives and staff told us that the unit managers were very approachable and supportive.

People were not always happy at the service. Feedback about the delivery of care varied. Privacy and dignity were not always promoted. People told us that they were not always able to choose how to spend their time or encouraged to make decisions about their care. People's care plans were detailed and person centred, however, this was not always the case with care delivery.

People gave mixed views about the activities available. People who were in their rooms were at risk of being isolated.

People, relatives and staff told us that there were not enough staff. On the day of inspection, we saw people were still receiving morning care on the approach to lunchtime. Care plans did not reflect that this was people's choices. There were systems in place to help ensure staff were trained and received regular supervision and staff felt supported by the management team. The recruitment process helped to ensure that people were supported by staff who were suitable to work in a care setting.

The service met the characteristics for a rating of "Inadequate" in two key questions and the rating of "Requires Improvement" in three key questions.

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 rating for this service was Good (28 August 2017). At this inspection the rating had deteriorated, and the provider was in breach of some regulations.

Why we inspected:
This inspection was brought forward based on information we had received.

Enforcement:
We have identified breaches in relation to people's safety and welfare, safeguarding people from abuse, nutritional management, governance systems, working in accordance with the Mental Capacity Act, and the lack of person-centred care and dignity promoted at this inspection.
For requirement actions of enforcement which we are able to publish at the time of the report being published:
Please see the action we have told the provider to take at the end of this report.

Follow up:
We may 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.

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?**

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 effective safe

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.

# River Court Care Home

**Detailed findings**

## Background to this inspection

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

Inspection team:
The inspection was carried out by three inspectors and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type:
River Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as 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 had 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.

Notice of inspection:
The inspection was unannounced.

What we did before the inspection:
Our inspection was informed by evidence we already held about the service. We also checked for feedback we received from members of the public and local authorities.
We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

During the inspection:
We spoke with the registered manager, the deputy manager, and 11 staff members. We spoke with 19 people who used the service and six relatives about their experience of the care provided. We reviewed 12 people's care records, medicines administration records and other records about the management of the service.

After the inspection:
We asked the provider to provide us with information detailing how they would immediately mitigate risks to people. We reviewed information provided by them to review if we felt the actions were effective.

Requires Improvement

# 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 requires improvement.

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.

Assessing risk, safety monitoring and management
●People had their individual risks assessed and the assessments were clear in most cases. However, care was not always delivered in accordance with these risks and management plans. For example, staff were seen to be lifting some people under their arms.
●We observed two staff members supporting someone to use a standing hoist. The transfer was very rushed and there was not any reassurance given to the person. At the end of the transfer the person was not back far enough in the seat, so the staff member put their hand under their arm to move them back. We also saw two staff were supporting a person to transfer from wheelchair to a chair in the lounge. The two staff went either side of the person and put their hand under the persons arm and were saying "Try and stand."
● People did not always have access to a call bell so they could summon assistance. On the two nursing care units, only one person had access to their call bell. One person said, "They take it away as I use it too much."
● We asked staff if people can use their call bells and they told us two people could use their call bells. However, we saw in the morning that call bells for the people who were able to use them were hooked on the wall and they were unable to reach it.
●People`s care plans did not detail if they could or not use the call bells and what other measures were in place for people who couldn't to ensure they were provided with the care they needed when they needed it. One person told us, "They said we use it (call bell) too often so they just took them away. You have to wait and call out if you see someone then they rush in and rush off even if you want something."
● Risk assessments were in place for people who required the use of oxygen. Staff were aware of the process and there was signage for the use of oxygen.
● A fire risk assessment had been carried out in 2018 and the actions identified had been signed as completed as part of an annual review by the registered manager and maintenance manager.
●Staff had attended fire drills and knew what to do in the event of an emergency. Evacuation sledges were available in case of an emergency. One staff member said, "If there is a fire the alarm will sound and the panel will show where it is located, there is instructions as to what to do for each person and we will be

given that by the fire marshal and we will act."
●People's individual evacuation plans (PEEPS) required further development in regard to evacuation from the first floor. For example, PEEPS did not explain how to get a person down the stairs.
● Accidents and incidents were added to the provider's electronic system. This system collated the information and included what action had been taken. In relation to falls resulting in serious injury there was a robust root cause analysis after the event.

Due to people's safety not consistently being promoted and placing people at risk, this was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● People who had bedrails in place had the protective bumpers on to help prevent them from injury and bedrail checks were in a place.
●Risk assessments were in place for choking, falls and weight loss. These were well completed and gave staff sufficient guidance to meet people's needs safely. Staff told us each person had their own slings and sliding sheet if they needed regular turning.
●People were assessed for the risk of developing pressure ulcers and where there was a risk identified pressure relieving equipment was in place to prevent this from happening. Mattresses were found to be set at the correct setting. The majority of people on the nursing unit needed staff assistance to mobilise, therefore there was a low number of falls recorded. People identified at risk of falls had sensor mats in place to alert staff if they needed help and were referred to the falls clinic.

Systems and processes to safeguard people from the risk of abuse
● People gave us mixed views about if they felt safe and why this was. One person said, " I feel safe because there's everybody around me."
● Safeguarding information displayed around the home including the whistleblowing advice line for staff which was on display.
●Staff working at the home had up to date training regarding safeguarding people from abuse and there was also information displayed around the home. Staff knew how to report any concerns they had within the home and we saw that staff reported concerns they had to the management team. One staff member said, "I would contact my manager or home manager, I may speak to the council if I am not listened to however, we are always listened to." However, the management team did not always take the appropriate action following this being reported.
●People were at risk of unsafe care because moving and handling procedures had caused injuries and no action had been taken in response to this. We saw that injuries had been caused when people had been supported by staff with their mobility. For example, one body map showed bruising under people's arms and we also observed people being lifted under their arms.
● There were several unexplained bruises and skin tears. Some were recorded on the provider's monitoring system as 'unexplained' but no investigation was noted or report made to the safeguarding team. We also saw that body maps had additional injuries listed but these were not on the monitoring system.
● Where a potentially unexplained bruise or skin tear was discovered on a person, these were not robustly investigated, and as such the provider could not satisfy themselves that the injury was not because of harm. Many injuries may have been linked to moving and handling techniques. For example, use of the hoist when people were distressed as no reassurance was given at times and people were recorded to be 'lashing out'. These incidents had not been reported through the safeguarding process.
● People had reported that staff had been rough when repositioning them and we saw staff not taking care or reassuring people when assisting them.

Due to the concerns found in relation to unexplained injuries and the lack of proper investigations or

reporting, this was a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staffing and recruitment

● People told us there were not enough staff to meet their needs. One person said, "They are always in a hurry to get to the next person, I think they must be short of staff, they are a bit slow when I have rung the bell as well." Relatives also told us there were not enough staff. One relative said, "There are not enough staff here, there's never enough staff, but the staff here run around and there's too much pressure on them and no time to spend any time with the residents."

● Most staff said there were not enough staff. They told us this meant people had to wait for support. On the day of inspection, we saw people were still receiving morning care on the approach to lunchtime. Staff told us some shifts were not able to be covered and they worked short staffed. One staff member said, "Six staff is not enough because in the morning you have to give medication and one person has to be in the kitchen so that leaves four. And majority of people need two staff to help them. If there was an emergency there wouldn't be enough staff. Also, if I'm assisting one resident and the others have to wait. They will come in the pyjamas because there isn't enough (time to get them dressed)." Another staff member said, "I think assisting with food we should have more staff, it's never enough. So many people need help. It can be difficult as you have to choose who is priority and other people have to wait." The registered manager told us that they had recently added one more staff member to support people at mealtimes. However, staff felt this had not resolved the issue.

●On the units that provided nursing care, a high number of people relied on staff assistance to help them change position in bed, to eat and drink and to wash and dress. Staffing levels on the units dropped in the afternoon although people's needs didn't change. For example, on the 30 bedded nursing unit 24 people were assessed as needing two staff to wash, dress and to mobilise and transfers with a hoist, 20 people needed regular two or four hourly turns and 23 people need help with eating. Each person also had to be checked hourly by staff. One person said, "I was nearly crying this morning waiting for the toilet, they say 'someone will come' and they don't. I've had [health condition] so I have to be careful, but I was in pain waiting."

●Staffing was established as two nurses in the morning and afternoon, six care staff in the morning but only four in the afternoon. The registered manager told us in the morning that the auxiliary staff as well as management staff helped meet people's needs to assist people to eat. However, this was not the case in the evening where we observed less care staff, and no auxiliary or management staff were available to support people. This put extra pressure on staff to meet people`s needs.

●Following the inspection, the regional manager told us people's dependency had been reviewed. As a result, they told us that the number of staff hours being provided was sufficient to meet people's needs at this time. The evidence found at the inspection, in conjunction with the feedback from people who used the service and staff, did not provide reassurance that staffing levels were effective in providing the care and support that people deserved.

The lack of monitoring of staff approach and attitude to people's needs and the deployment of staff was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● Recruitment files included information to help the registered manager make good decisions about the staff they employed.

Preventing and controlling infection

● The home was clean on the day of the inspection. The housekeeping staff were moving around the home and cleaning all areas. Housekeepers observed were very friendly, they knew people and had a chat and a

smile for everyone.
● Staff had received training and were seen to use gloves and aprons. However, we noted that at times staff left people's bedrooms with their gloves still on and proceed to the sluice room or laundry store to collect clean bedding. We saw that staff kept these same gloves on which had been used to provide personal care to people.

Using medicines safely
● People's medicines were administered, stored and recorded safely. We counted a random sample of medicines and found that the records and quantities were correct
● Regular checks and audits were completed. This included daily counts of boxed medicines.
●People received their medicines when they needed them, including time specific medicines. However, we did note that one person did not always receive their medicine two hours before or after food as required.

Learning lessons when things go wrong
● Staff told us that lessons learned were shared by their unit managers with them. One staff member said, "We see our (unit) manager every day. They are very supportive. We have supervision every three months. We have a group supervision and if she has concerns we will have those discussions."
●We reviewed some staff meeting notes and found that they had discussed some areas of practice, such as moving and handling. However, they had not addressed all of the concerns we found during this inspection which demonstrated the management team had not identified the shortfalls.
● The provider had not shared learning about issues that impacted on people across their locations about lessons learned.

Requires Improvement

# 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 requires improvement.

Requires Improvement: This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Supporting people to eat and drink enough to maintain a balanced diet

● People told us that they liked the food offered. One person said, "The food is good always something to choose from, they don't let you go hungry." Another person told us, "The food is ok, we get a couple of choices, I had an omelette the other day, that was very nice."

● Food choices were taken earlier in the day but staff did not check with people who may have short term memory loss or remind them what they had chosen when delivering the meal to the table.

● On one unit there were tables to seat up to 16 people, the unit is full and capacity is 30. There were 16 people sitting on lounge chairs with pull up tv tables that were not offered the opportunity to sit to a table.

● We observed two staff talking across the table to each other whilst they assisted two people with their meal. Where people were having to wait for help to eat their meal, we saw one person lost interest after they had to wait for over 30 minutes for their meal to be served. When reviewing the documents, staff told us there was no record kept of how much the person ate.

●When speaking with a staff member about people's modified foods they were able to speak about each person who needed their food and drink modified. However, people who required a modified consistency diet all received their food pureed to the same consistency.

● The kitchen staff spoken with had not received training on different levels of consistency in accordance with SALT (speech and language therapist) guidance. The chef on the day did not have an understanding of the descriptors when modifying diets. When asked what their understanding of dysphagia was they asked, "It is an allergy?"

● People living in the home had a range of dietary needs. Some people's cultural and religious beliefs influenced the type of diet they had, where other people needed modified or specialist diets due to their health needs.

● People's care plans contained information about their dietary needs and what type of foods they liked and disliked, however although there was a folder available with people's dietary needs recorded, when

asked staff, the deputy manager and registered manager told us that they did not have this information at hand when they served meals and worked from memory. This meant there was a risk that people could receive food that they couldn't eat for health reasons or would not choose to eat for cultural reasons or preferences.

● The home Vegetarian for Life accredited. On the day of inspection there was a meat or fish choice. The kitchen staff did not recognise that not all vegetarians ate fish.

● Staff offered people choices and wrote down numbers of menu choice one or two for kitchen staff without detailing the name of person who had requested these. This meant that the chef sent out a set quantity of menu choice one and two. Staff then served people from the hot trolley. Staff did not know what type of fish was provided. When asked by people staff told them it was, "Baked fish" but not the type of fish.

● Food and fluid charts were completed for those assessed as being at risk of not eating or drinking enough. Fluid targets were set and amount totalled in most cases.

●Drinks were not always available for people. One person said, "I'd love a drink, haven't had one for a long time". A staff member said, "[Person] has had a drink, they just spill it on the floor on anyway." We told the staff member that the person was thirsty and they went away to get a drink. We observed later that a drink was in front of the person and this had not been spilled. One person in a bedroom called out to us to ask us to move a table to have the drink moved closer to them.

● Where people were at risk of losing weight, there were management plans in place to address this.

Due to the poor systems in place to ensure people's nutritional needs were consistently met, this was a breach of Regulation 14 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Supporting people to live healthier lives, access healthcare services and support

● People were supported to have access to outside professionals. One person told us, "I get my hair done, I have had it done today, the chiropodist comes every six weeks or so, and if you need a doctor they will call one, but I think the doctor visits here every week."

●A GP visited weekly and a list would be made of anybody wishing to see the doctor, and district nurses made daily visits to the units not providing nursing care.

●A hairdresser, chiropodist, dentist, and optician all visited the home on a regular basis.

● We saw that all changes in health were documented.

Ensuring consent to care and treatment in line with law and guidance

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

● People can only be deprived of their liberty to receive care and treatment 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).

● People were not supported consistently in accordance with the principles of the MCA. People had their capacity assessed in relation to receiving 24 hour support and living in a care service. In some cases, best interest decisions were recorded. However, this was not completed consistently for all decisions relating to their care.

●Staff received training relating to the MCA and most of them were aware of what this was and what this meant to people. Some staff said they would look at what is in the care plan, however evidence from the care plans showed not everyone had an MCA where it was needed. One staff member said, "We need to

make best interest decision. If there is change then we would make sure we look into this. We make decisions about food choices, activities, going out, personal care. One or two of people have said they want to go out so the activity person will take them out."

● Staff told us on one unit they had applied for DoLS for everyone because it was a locked unit and everyone lacked capacity. People's mental capacity for specific decisions were not always carried out. For example, for two people MCA's were carried out for decisions such as having a locked door and the use of bedrails, however another person who was up and walking, told us they felt locked in and there was no capacity assessment to assess if they had capacity to go out.

●We noted all doors had keycodes on and information with regard to the keycode numbers were not accessible in order to help people who were able have access to going outside. Staff did not all know the codes, nor did some members of the management team and these codes varied within units making it impossible for people to know how to leave the building even if they had been told the codes. One person told us, "The doors are very secure, I have been here three years, and even I don't know the codes for them." Three people told us that they wanted to go home but they were not 'allowed' to. We asked the registered manager to review their assessments and ensure that they were not being unlawfully restricted.

●DoLS applications were made in relation to receiving 24 hour support and living in a care service but there were no authorised applications recorded at the time of inspection. People did not have support plans to instruct staff on how to support them in the least restrictive was possible while waiting for the DoLS authorisation.

The policies and systems in the service did not ensure that the principles of the MCA were consistently applied. This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014

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

● Staff told us that people, and their relatives where appropriate, were sometimes involved in planning care. However, there was no signatures within the care plans to confirm the person or their representative had endorsed its content. However, people told us they didn't know what a care-plan was and couldn't remember if they or their relatives had signed anything.

● People told us that staff asked them before support was given. One person said, "They will always ask permission before they do anything."

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

●Some bedrooms were personalised, and people had their personal items around them. The home is designed in a way that people can move around easily whether independently or with the use of mobility aids. The home was clean and odour free.

● There was ample communal space which was decorated nicely, and we saw people using the main lounges and dining room.

● There was a pleasant garden area which people used.

Staff support: induction, training, skills and experience

●Staff told us training was regularly planned. One staff member said at times training was planned while they were on shift and this meant they couldn't always attend the courses. They preferred that more training was now delivered on a face to face basis and not just online training. We saw that most training was completed but some training was due to be updated.

●Staff told us they had supervisions and staff meetings. Staff we spoke with felt supported by their unit managers. One staff member said, "We have a unit manager, who I see. I have been here six months, if there are any changes to the support we will get a formal supervision every three months."

Staff working with other agencies to provide consistent, effective, timely care

● The home was being visited by the clinical commissioning group to improve care for people. However, actions arising from these visits had not been fully implemented by the service. For example, in relation to safe moving and handling.

Inadequate

# 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 inadequate.

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
● Some people told us that they felt the staff were kind and respectful. One person said, "I usually see the same staff come to help me, I don't mind they are all lovely, there is no nastiness in here." A relative told us, "The carers are very approachable, from the office, admin to the kitchen."
● We were shown statistics from an internal survey which showed that feedback about staff was positive.
●However, some people told us that they didn't always feel respected. One person said, "[Name of staff member] always pats me on the tummy and says when is it due. It makes me feel self-conscious." That also said that a staff member called the person by the staff members name as they were similar, but they didn't like it.
●People were not always treated with respect and kindness. We saw people asked for support and staff at times ignored these requests or dismissed them. For example, one person asked to be repositioned in their chair and staff told them they would take them for lunch soon. When they realised they were being observed they assisted the person to sit back in their chair. Another person dropped their cutlery on the floor and wanted them replaced and told the staff member, the response by the staff member was, "No it hasn't." They walked away and left the person with dirty cutlery. A third person was accidently walked into by a staff member. The staff member continued about their task but when they saw they were being observed they stopped and apologised to the person.
● Some people's life histories, religion or cultural beliefs, hobbies and interests were recorded in people's care plans. However, we could not see how this influenced staff approach and improved people's lives.
●There was limited communication with people whilst eating and staff did not always provide support in a dignified way. For example, one staff member failed to wait for the person to finish their previous mouthful before the gave them the next. One person said, "I watch the people with dementia at lunch sometimes and they push their food in whether they want it or not, it's disgusting."
● One staff member poked a sleeping person on the shoulder and said, "Bread for soup." During the 20 minutes we observed the same person was asked the same question (being woken up each time) five times

by different staff.
● Some staff were more attentive and stopped and chatted with people. A unit manager told us how they were advocating for a person who was not yet ready to go home, and they felt obliged to make sure they were not left vulnerable when they went home. We also heard other staff laughing with people while they supported them and demonstrated that they had a good relationship.
● One person was distressed about when they could see their relative. We asked if they had a phone to call them. The person said they were not allowed one. The staff member intervened and said to the person they could support them to call their relative. This was done straight away. Another relative said they feel very welcome. "You can come whenever you like. On Father's Day they gave us the quiet room so we had time with our family."

Supporting people to express their views and be involved in making decisions about their care
● People told us that they were always involved in planning or reviewing their care. Relatives told us that they were involved. We saw in care plans there was information about people's likes and dislikes.
● People told us there wasn't much choice about going to bed and getting up. One person said, "They seem to do it when they have time." Another person said, "They've never asked me, I suppose I just accept and if I get ready for bed I can still watch the TV from bed so it's not too bad."
● We heard staff asking people's choices throughout the inspection.

Respecting and promoting people's privacy, dignity and independence
● People were dressed appropriately, and we saw no one in a state of undress while in bed.
● Staff knocked on doors before they entered
● Care plans were stored in a secure office. However, a person's care plan was detailing confidential information from their past which could have had an impact on how staff saw them as a person. Although the confidential information was throughout their care plan there were no risk assessments of how this may impact in the day to day life of the home or staff relationships with them.

People were not being treated respectfully and dignity was not being promoted, this was a breach of Regulation 10 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Requires Improvement

# 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 requires improvement. At this inspection this key question has remained the same.

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 did not receive personalised care and support. People told us that they would like more showers. One person said, "I have never been asked if I prefer a male or female to care for me, but I actually don't mind, but I would like more showers, they just presume I'm ok with a wash." Another person told us, "I can wash myself, but I miss having a shower, (name) my carer has left, and there aren't that many females to support me now, I only want a female to shower me." We reviewed the care records which related to the personal care for people living in one unit which supported 30 people. During the 18 days of June, only seven of the 30 people on the unit had received showers and with one exception, people had only received one or two showers during the 18-day period.

●Care plans were detailed and included sufficient information for staff to be able to support people safely. Pre-assessments were carried out before people moved in. This looked at all aspects of personalised care and details if these could be met. The assessment looked at what risks were involved and what equipment was needed.

● Staff were not responsive to people's needs. There was not a clear understanding of what people wanted. For example, whilst someone was eating their meal they wanted help with their fork, however the staff member failed to take the time to listen to them and changed the fork and knife around in the person's hand and walked away.

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

● People told us that activities provided needed to be improved. One person said, "I don't like any of the activities other than the bingo, or a good quiz, I would complain but I can't be bothered."

●People in their rooms had little stimulation. One person said, "I do get very bored in here, I have had a stroke, I can't join in much, other than answer questions from a quiz, most of the day there is nothing for me to do." Another person told us, "When the choir comes to sing, people like that, but they don't put on

enough 'shows' that some of the people would like."
● People told us that they relied on their own independence and family members to arrange to go out. One person was going out with a staff member the next day.
●An activity leaflet was printed and distributed to people's rooms. We saw that these activities offered were generic and did not take into account people's individual preferences.
● On the day of inspection, we saw there were communal activities available in the lounge. However, one person was noted to be on the other side of the room and trying to listen to the quiz. The activities person said, "I would bring [person] over but they need to be hoisted." No attempt was made by them or care staff to offer the person the chance to move to where the quiz was being held.

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.
● There were no aids available to support people with communication when they were unable to verbalise choices. Staff did not show visual prompts to people. Staff told us that people were unable to verbalise with us. However, we found that we were able to communicate with some people who staff told us we would not be able to do. This indicated that staff did not make a regular effort to engage or communicate with people.

Due to care not being delivered in a person-centred way, improvements to the way people were supported to communicate and a need to further develop activities so that they meet everyone's needs, this was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

End of life care and support
● The service offered end of life care. When people were nearing the end of their lives, care plans were put into place for supporting people.
● These plans were completed in detail and they stated if a 'Do not attempt cardio pulmonary resuscitation' (DNACPR) was in place. The persons preferred place of death was noted and to keep people comfortable. Just in case medicines were prescribed for people nearing the end of their lives. This meant that people were supported to die in a pain free and dignified way.

Improving care quality in response to complaints or concerns
● Records stated that complaints and concerns had been captured and responded to appropriately. The registered manager reviewed these to have oversight of themes and trends of issues in the home.
● People gave mixed views about the response to complaints. One person said, "I have complained about two members of staff and people have complained about other things, but nobody listens." A relative told us, "Generally if there are issues they will do their best to deal with things."

Inadequate

# 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 was because there were a number of concerns in the home that resulted in breaches of regulations.

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 are clear about their roles, and understand quality performance, risks and regulatory requirements

- The registered manager used the internal governance systems to help them identify issues in the home and they had identified some areas that needed improvement. Care plan audits on the resident of the day and issues were identified, for example if the dependency rating scale was not up to date.
- There was a resident of the day initiative looking at medicines, weight, care needs for people. The registered manager carried out a twice daily walk around, reviewing the environment and staff interaction and people's appearance. However, they had not identified the areas of concern we found on inspection as part of the quality assurance process.
- The regional quality team visited the home weekly to check on the progress of issues they had identified in the home and the progress of the action plan they had developed. However, the shortfalls identified on inspection had not been identified through this process.
- The management team had not ensured that care was delivered in a way that promoted people's rights and people were not restricted. The systems in place did not identify that the approach did not adhere to the Mental Capacity Act.
- The management team had not ensured that staff attitude and approach gave people the care they needed and deserved. They assessed dependency and satisfied themselves that staffing levels were sufficient. No consideration into staff deployment or staff prioritising people's needs had been made.

Working in partnership with others

- The registered manager had not ensured that other agencies were informed of all issues arising. They had reported some concerns in relation to allegations of abuse and reported serious injuries appropriately.

However, where people had unexplained injuries, this was not reported to the local authority nor was it reported to the CQC.

● We shared our concerns with the local authority and clinical commissioning group (CCG). These agencies fund the care for some people living at the service. The CCG had been visiting the service as they had concerns about the nursing care being delivered. However, although the service had made progress with the CCG's action plan, the management team had not ensured they effectively used this support to make sure people received the correct care. For example, moving and handling training had been provided but staff were still seen to use unsafe practices.

Continuous learning and improving care

● The learning from the home's recent issues and ongoing performance issues had been shared with the home's staff for any required actions to be taken. Staff were reminded about attending training and were issued performance letters if they did not attend. This relating to moving and handling. However, this had not been effective, and this had not been identified as not being effective by the internal systems.

● The provider had been informed by the CQC about concerns across their locations which included unexplained injuries not being investigated or reported. The registered manager told us that they were aware of this learning. However, they told us that this was something that they needed to implement. The provider had not ensured that learning from inspections across their other locations had been used positively to impact on the running of this service.

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

● People and their relatives had meetings to discuss the service. One person said, "They have a meeting every few months, I think, people mostly complain about the activities." Another person told us, "I didn't know there were meetings held, nobody said, I have been given something once to fill in about the home, but that was a while ago."

● The resident meetings looked at activities and menus and gave some information about the home.

● Care staff meetings included reminders of good practice. However, kitchen staff meetings did not reflect dietary needs and activity meetings did not reflect people's preferences and planning to incorporate these.

Provider plans and promotes person-centred, high-quality care and support, and understands and acts on duty of candour responsibility when things go wrong

● Not everyone who lived at the home knew who the registered manager was. One person said, "[Name] is the manager I see them around sometimes, I can't say I have seen any improvements, and I have been here three years." Another person said, "I don't know the main manager, only the bosses on this unit."

● We were told by people, relatives and staff that the unit managers were available if anyone needed to speak with them. One relative said, "The unit manager on here is fantastic, they have gone above and beyond to support my [relative] in here."

●A staff member told us, ""The manager is really supportive we have hand over in the morning, so we can have a chat."

●As part of their monitoring systems the management team had not identified or addressed the concerns in which some staff treated people or that care was not person centred, or in some cases, unsafe. This did not demonstrate that the provider was committed to providing high quality or person-centred care.

Due to the shortfalls and breaches found as part of this inspection, this was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

# 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 9 HSCA RA Regulations 2014 Person-centred care |
| Treatment of disease, disorder or injury | People did not receive care in a person centred way. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA RA Regulations 2014 Dignity and respect |
| Treatment of disease, disorder or injury | People were not always treated with dignity and respect. |

| 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 | People did not always receive safe care and treatment. |

| 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 |
| Treatment of disease, disorder or injury | People were not always protected from the risk of abuse as unexplained injuries were not reported or investigated. |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs<br><br>People did not always receive the appropriate support with nutritional needs. |

# 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 17 HSCA RA Regulations 2014 Good governance |
| Treatment of disease, disorder or injury | Governance systems failed to identify and address the issues found at the service. |

**The enforcement action we took:**

We issued the provider with conditions on their registration to help drive improvement.