Parkside Nursing Home Limited

# Parkside Nursing Home

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

About the service
Parkside Nursing Home is a residential care home providing personal and nursing care to 25 older people and those who live with dementia at the time of inspection. The service can support up to 34 people.

People's experience of using this service and what we found
Risks associated with people's care were not always managed in a safe way, particularly in relation to the safe management of medicines and good infection prevention and control practice. However, people and their relatives told us they felt safe and the provider had systems in place to ensure safe recruitment of staff.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. People's consent to care was not always evidenced and application of the Mental Capacity Act 2005 was inconsistent. Staff training was not effective in ensuring consistent good practice within the service. People's needs were assessed prior to moving into Parkside Nursing Home and they had regular access to healthcare professionals, and they complimented the quality of food provided.

We found that some of the language used by staff was not respectful and at times, aspects of people's dining experience lacked dignity. Care plans were not always person centred and they lacked guidance around the needs of people. When people's needs changed, these were not always updated in their care plans.

People's end of life care choices were not always clearly documented and people cared for in their rooms did not always have access to meaningful activities. People told us they were confident they would be listened to if they made complaint. At other times we found staff treated people with kindness and took time to make sure they were comfortable.

Quality assurance processes were not effective in identifying and delivering required improvements to the service which meant people were at risk of not receiving a consistent or safe service in line with their needs. There was a lack of robust management oversight of the service. However, people and staff spoke positively about improvements initiated by the recently appointed the manager.

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 requires improvement (published 19 March 2019) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider had not made enough improvement and remained in breach of regulations. This service has been rated requires improvement for the last two consecutive inspections.

Why we inspected
This five key question inspection was prompted in part due to concerns received about infection control, medicines and nursing care. A decision was made for us to inspect and examine those risks. We also checked if they had followed their action plan and to confirm they now met legal requirements.

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

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

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We have identified breaches in relation to medicines administration, consent, staff support and training, person-centred care and governance of the service.

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

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

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not always safe.

Details are in our safe findings below.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

Details are in our effective findings below.

### Is the service caring?

**Requires Improvement**

The service was not always 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?

**Requires Improvement**

The service was not always well-led.

Details are in our well-led findings below.

# Parkside Nursing Home

**Detailed findings**

## Background to this inspection

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

As part of this inspection we looked at the infection control and prevention measures in place. This included checking the provider was meeting COVID-19 vaccination requirements. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by two inspectors and a nurse specialist advisor. We also had an Expert by Experience who made telephone calls to family members. 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
Parkside Nursing Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Parkside Nursing Home is a care home with nursing care. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. At the time of our inspection there was not a registered manager in post.

This inspection was unannounced.

What we did before inspection

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

During the inspection
We spoke with four people who used the service and one relative about their experience of the care provided. We spoke with nine members of staff including the manager, peripatetic manager, operations manager, nursing staff, senior care workers, care workers and the activities co-ordinator.

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

After the inspection
Our Expert by Experience spoke with seven family members. We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

Requires Improvement

# Is the service safe?

## Our findings

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

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

Using medicines safely

- Medicines were not always safely managed. We observed one nurse leave people's medicine with them and left their room without ensuring the medicine was taken. We also observed there was medicine left on the medicines trolley in a public area whilst the nurse went to a person's bedroom.
- We were advised by the nurse that when they were busy, care staff assisted with the medicines round on occasion, which care staff confirmed. We were also told that care staff checked medicines with the nurse when there was only one nurse on duty. The manager told us that was not the expected practice since care staff were not trained in any aspect of medicines administration or handling. They said nursing staff were wholly responsible for administering and checking medicines. There was no discernible impact on people's health as a result of this poor practice.
- The manager told us that nurse's competency to administer medicines were not checked. Following inspection, they confirmed to us that they had done brief observations with each nurse and arranged for competency assessments to be undertaken without delay.
- One nurse who worked at the service for many years as an agency member of staff told us they did not participate in any training provided, this included training for safe administration of medicines in care homes.
- There were protocols in place for 'as required' medicines. We saw that whilst one person was regularly administered prescribed 'as required' medicines, there was no record kept of why this was required and what the impact on the person was, in accordance with the protocol. The administering nurse was unable to tell us whether the administered medicine was adequate to manage the person's pain sufficiently.
- People's creams were applied by care staff, however, we saw that nurses signed the medicines administration records, despite not having been responsible for applying the creams.
- The provider's medicines policy was out of date and was due to have been reviewed in October 2020.

The failure to always manage and administer people's medicine in a safe way was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Preventing and controlling infection

- We were not fully assured that the provider was promoting safety through the layout and hygiene practices of the premises. There were soiled incontinence pads in an open bin in one of the bathrooms. We saw there were several slings hanging together on a hoist which presented an infection control risk. We found one sluice room was unlocked and there was a soiled commode bowl and used disposable glove sitting on a shelf. One person's room smelled very strongly of urine. The provider submitted photographic evidence following inspection which showed that they had addressed most of these infection risks.

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

We have also signposted the provider to resources to develop their approach.

From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency. We checked to make sure the service was meeting this requirement.

The Government has announced its intention to change the legal requirement for vaccination in care homes, but the service was meeting the current requirement to ensure non-exempt staff and visiting professionals were vaccinated against COVID-19.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
● There were occasions when risks associated with people's care were not always managed in a safe way. For example, there were no risk assessments in place to ensure people were supported to smoke cigarettes safely. The manager addressed this and there were risk assessments in place for people who smoked in place, by the end of the inspection day.
● Other aspects to the risks around care were managed appropriately. We saw risk assessments that related to people's mobility which were updated monthly. There were also risk assessments in place for use of bed rails, falls, nutrition and hydration.
● Regular environmental checks were carried out, including Legionella and water temperatures.
● Weekly fire alarm tests were undertaken and there were Personal Emergency Evacuation Plans in place for people with details around how they needed to be supported in the event of an emergency. Staff took part in regular fire safety training which included mock evacuations.
● Systems were in place to record accidents and incidents. However, improvement was needed as to how incidents were recorded. Nurses recorded all incidents, regardless of whether an incident was witnessed by a member of care staff. One care worker told us, "We have to tell the nurse if we see something [incident] and they write it down. We do not make any records of incidents; all the record books are all with the nurses."
● We noted there were occasions when some of the information included minimal detail. For example, one incident was recorded as a 'behaviour incident' without any other details recorded. In another, where a witnessed fall was recorded, there was no further information about actions taken.

Systems and processes to safeguard people from the risk of abuse
● People and their relatives told us they felt safe from abuse. One person said, "I have no concerns, staff are very kind to me."
● A family member told us, "I would assume so; I haven't seen anything to suggest otherwise," and another said, "Safe? Definitely safe there."
● Safeguarding procedures were followed, and staff understood what to do to ensure people were protected from abuse. One staff member commented, "If I saw it, I would report it. I would go to complain to the nurse or manager in charge."

● There were established policies and procedures in relation to safeguarding in place and records confirmed that staff had received safeguarding training. However, we found that some staff were unfamiliar with the term 'whistleblowing' and how to escalate concerns outside of the home.

Staffing and recruitment

● People told us there were enough staff, one person said, "Staff come when I ring and I have a bath whenever I ask for one." One family member told us, "There always seem to be staff around" and another said, "I'm pretty sure there are enough staff on duty, [relative] is always clean and changed when I visit."

● Care staff told us there were sufficient staff on duty. One said, "We're pretty well staffed now", and another told us, "It's a small home and there are enough staff here. Wherever we go for help there is always someone there."

● The provider used long term agency staff to provide consistent care to people. The operations manager told us that recruitment of permanent staff was a challenge and in the meantime, "We continue to work on recruitment and our aim is to build a stable and permanent staff team."

● The provider had systems in place to ensure safe recruitment of staff. Required safety checks had been made before staff started work. We saw that nurse registration checks were also carried out regularly to ensure nurses were registered with their governing body, the Nursing and Midwifery Council.

Requires Improvement

# Is the service effective?

## Our findings

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

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

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

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

At our last inspection in February 2019 we found the provider did not always obtain people's consent appropriately. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 11.

- Where decisions were being made for people, there was not always evidence of decision specific assessments to determine whether they lacked the capacity to make these decisions for themselves.
- For example, we were told that one person's cigarette allocation was reduced to three cigarettes per day. There was no evidence that this had been agreed with the person or that their capacity had been assessed to determine whether they were able to consent to this.
- There was some confusion about how the principles of the MCA were applied. For example, one person's record stated they had full capacity. However, a DoLS application was recently submitted to the local authority which cited that the person was being restricted from leaving the home; there were coded doors and they had bed rails in place.
- Staff were unclear about the principles of the MCA. One told us they had not done any training and they did not know what the main principles of the act were. Another told us, "I have not done the training."
- The provider's current training record showed that 48% of staff had not done Mental Capacity Act training.

The provider failed to always obtain people's consent before any care or treatment was provided. This was a continued breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff support: induction, training, skills and experience

At our last inspection, we recommended that the provider ensured all staff completed mandatory training. Not enough improvements were made.

● Although training was provided to staff this was not effective in ensuring that staff understood what they needed to do. During the inspection we found shortfalls in practices around medicines, management of risks, MCA, and dignity in care (this is reviewed in the caring part of this report).
● The provider's training record showed there was poor compliance with many of the mandatory training provisions. For example, 85% had completed moving and handling training, 76% of staff had completed training in personal care and 59% had completed behaviours that challenge.
● Compliance with additional training was significantly lower. For example, 48% had completed dignity in care and falls awareness training and 37% had completed dementia awareness.
● Care workers told us they had a two-day induction before commencing work. One told us, "Two days induction were given. We shadowed [an experienced member of staff] and they were teaching us to do the hoisting and feeding and everything."
● We were told that staff did not have the opportunity to have supervision with a senior member of staff to ensure they understood key areas of their responsibilities and to discuss any challenges or issues they might experience in their role. The manager told us that they had not yet managed to do supervisions with the staff team, "I will be having a one to one with every member of staff and will do this in a constructive way…. I want to convey to staff what has gone well and where we have to improve."

The provider failed to ensure that staff received appropriate support, training, supervision and development to carry out the duties they were employed to perform. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
● The design and decoration of the home did not always meet the needs of people who lived with dementia. It is generally recognised that people who live with dementia are best cared for in an environment designed and adapted to help reduce their anxiety and potential triggers for distress.
● There were no meaningful, sensory or stimulating destination places around the home for people to visit or engage with when they walked with purpose. There were no clear signs placed at key decision points for people to orient themselves. The menu board in the dining area was almost illegible and had not been updated for four days.
● The communal bathrooms had heavy slide doors which were difficult for people to open without staff assistance. There was a large pillar in the living room, which obscured some people's view of the television from the chairs they sat in.

We recommend that the provider improves the environment to make it more suited to the needs of those people who live with dementia.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to eat and drink enough to maintain a balanced diet; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare

services and support

● Information about people's needs had been assessed before they moved in. This was to ensure that they knew the service could meet their needs.

● The provider used nationally recognised assessments, including a malnutrition universal screening tool to identify adults who are malnourished or at risk of malnutrition and a Waterlow score, which assessed the person's risk of developing a pressure ulcer.

● The provider managed people's nutritional needs to ensure they received a balanced diet and sufficient fluids to keep them hydrated. We saw that people were frequently offered drinks throughout the day and snacks were readily available. Fluids were within reach of those who remained in their rooms.

● One person told us that they enjoyed the food and said it was good quality. A family member told us, "[Relative] is now on pureed food which looks quite appetising. Chef has offered to do anything [relative fancies] and said they would puree it." Another told us, "Food is one good thing about the place. [Relative] doesn't eat a lot but no matter the time of day, they will get it. Porridge for lunch, marmalade at teatime, whatever they want."

●The chef kept a record of people's nutritional requirements. These included allergies; likes and dislikes and whether people required a softer diet that was easier to swallow. They told us that any changes in people's needs were relayed to them by the nurses.

● Records showed that people were supported to access healthcare when required. There was frequent contact with the GP and evidence that other healthcare professionals were referred to. A family member told us, "They do look after [relative's] health. They recently lost a lot of weight and called in the doctor and now they are monitoring it and giving fortified drinks." Another told us, "They got a chiropodist out within a day or two when I asked"

● The chef told us that, "The dietitian will come and speak to me once they have done an assessment, and I follow their instructions."

Requires Improvement

# Is the service caring?

## Our findings

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

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

Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care

● People were not always treated with dignity and respect and there were times when undignified language was used. For example, we overheard one care worker tell another, "Put [person] in the corner," rather than asking the person where they preferred to sit. Staff told us they "fed" people rather than assisted them to eat. We saw staff standing over people as they assisted them to eat, rather than adapting an appropriate position to make the dining experience more comfortable and dignified for the person.

● On another occasion, when a person made a particular request, a care worker said, "One minute I will get it for you" when in fact their request was not fulfilled for a further 18 minutes. The care worker subsequently commented in our hearing that the person was angry, "Because I didn't give it to [person] straight away."

● There were times when we observed staff enter people's bedrooms without knocking or waiting to be invited in. On one occasion, a person's bed was adjusted without any warning whilst they were in it, which made the person cry out in surprise.

● People were not always supported to make informed decisions around their meal choices. Staff told us that food choices were discussed earlier in the morning and was done without any visual aids to assist the person to make an informed choice. They acknowledged that those who lived with dementia were likely to find it difficult to engage in this conversation without seeing photographs of the food or without being shown the meals on offer at lunchtime. We heard one person ask what the dish in front of them was at lunchtime. The care worker was uncertain and incorrectly identified the food on the plate.

● There were two tables in the dining area, each of which enabled four people to eat their meals at, a third table was used to hold paperwork. All others ate in the lounge area from small tables placed in front of them. The home had capacity for 34 people and whilst not everyone could or would choose to eat in the dining area, this reduced their choice to do so.

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

● There were other occasions when we saw staff being kind and caring with people. People told us that staff were kind and caring. One person told us, "Staff are very kind, very gentle," and another said, "staff are really nice."

● A family member told us, "I think they [staff] are kind, whenever I've seen staff with [relative], [relative] has been very relaxed, they get on well with staff," another told us, "Yes, I would say they are kind, I can't fault them."

● Whilst some people could not tell us how they felt about staff, we observed positive interactions between people, relatives and staff. We heard friendly chat and laughter between people and care workers during an

activity in the lounge.

● We observed how one care worker gently encouraged and physically supported a person to move from their wheelchair to a chair. At other times, staff comforted and offered reassurances to people who were unclear where they were.

Requires Improvement

# Is the service responsive?

## Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained the same. 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; End of life care and support

At our last inspection in February 2019, we found that people's care plans did not always hold accurate information about their care. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.

- Care plans were not always person-centred and did not always evidence whether people were engaged in planning their own care.
- Family members told us, "I don't think there's a care plan, I've not had any involvement in one." Others said, "That's a good question and I should probably check up on whether there is one," and "No, but [relative] has only been there for a couple of months."
- Peoples needs and preferences were not always reflected in their care plan. For example, one person's risk assessment highlighted that they were unable to ring their call bell to summon staff. However, their care plan did not reflect this and there was no guidance in place for how this person could call for staff support if needed.
- We found conflicting information in some people's care records. The front sheet of one care record highlighted that the person was not at risk of choking. However, their care plan identified them as being at high risk of choking. We brought this to the attention of the nurse on duty who told us that the front sheet should be updated to reflect the person's needs which they subsequently amended. We confirmed that all staff knew the person was at high risk of choking and they were supported according to their nutrition care plan.
- Another person's care plan referred to a pressure ulcer, however, the last record on their wound chart was dated 16 January 2022. The nurse in charge told us that the wound had healed and confirmed that the care plan was not updated to reflect the persons change in need.
- Some care plans lacked detail. For example, one person's skin integrity nursing care plan identified they required frequent repositioning, however, there was no guidance on what that frequency should be or if the person had been involved in discussions about how they wanted to be supported with repositioning.
- We found that where people had food and fluid charts or repositioning charts in place, these charts were seldom updated by the night duty staff. This meant that people's care and treatment plans were not maintained. This was a breach of Regulation 9(3)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Care workers told us told that they were not expected to read people's care plans. One told us, "we document what we care we give [in room folders], but we don't read the care plans. After one week we get to know about all these things by observing others and following what we are told [in handovers]."
● End of life care plans lacked detail about people's preferred end of life care. There was insufficient evidence that discussions took place with people including people's spirituality, religion, what family they wanted around them and where they wanted to be at the end of their life.
● For example, one person's end of life care plan recorded that the person wanted a 'compassionate, passionate empathetic and dignified end of life care,' with no detail of what this might mean to the person or how staff should deliver this care.

The provider failed to improve on the quality and consistency of information contained in care plans. This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

At our last inspection, we recommended that activities should reflect people's preferences. At this inspection, we found this had not improved for people who were cared for in their rooms.

● People were not always provided with activities that met their preferences and interests. We observed on the day that those who lived with dementia were not always sensitively or proactively engaged with the activities provided.
● We found that people cared for in their rooms were at risk of being socially isolated due to the lack of provision of social activities for them. We were told there was daily one to one engagement with all those in their rooms and were shown a daily chart with ticks on each day of the week to evidence this.
● However, on further exploration, we confirmed that the majority of these interactions which were considered as one to one engagement was when a member of staff went to the person's room solely to ask what their lunch and tea preferences were for that day.
● There was an activities coordinator on site Monday to Thursday, and we were told that a plan of activities was left for care staff to follow at the weekend. Care workers told us they were not aware of this and that no activities took place at the weekend.
● There was no record kept of the impact activities had on people and how they might be of benefit to them. We spoke with the manager about this and they agreed that activities records should be detailed and evidence how they benefited people.

The provider failed to improve activities to support the needs and preferences of people cared for in their rooms. This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There was a range of activities taking place in the lounge on the day of inspection which many people seemed to enjoy. Those who could, engaged with each other and with staff who facilitated the activity.

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

relation to communication.

● People's communication needs were recorded as part of the initial assessment and care planning process in a separate communication needs care plan. For example, one person's communication care plan stated staff should communicate with them in, 'short and clear sentences.'

● Staff took time when speaking with people to ensure the person knew they were being spoken with. They were aware of people's preferred form of address and we heard staff address a person according to how their communication care plan stated they wished to be addressed.

Improving care quality in response to complaints or concerns

● The provider did not maintain a complaints folder which meant there was no oversight of complaints submitted or how they were responded to. The operations manager told us no complaints were made. They also said they would establish a complaints folder for better oversight.

● People told us they would not hesitate to make a complaint if they had a reason to. One told us, "I get on with it, I cannot think what I would complain about."

● Family members told us although they had never had reason to complain, they knew how to do so. One told us, "No, [I have] no complaints or issues" and another said, "I made a complaint only once. Just had my say, aired my views, and yes I was satisfied with the result."

Requires Improvement

# Is the service well-led?

## Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

At our last inspection, we recommended that the provider reviewed its quality assurance systems to ensure areas for improvement are identified. At this inspection, we found this had not improved.

- The service did not have a registered manager in post at the time of the inspection. There was a manager in post who was supported by a peripatetic manager as well as the operations manager.
- Effective management systems were not in place to assess, monitor and improve the quality of service people received. The systems which were in place were not effective in identifying concerns and areas for improvement found at this inspection.
- There was a lack of robust oversight from the provider to improve the quality of records and care being provided. Care plans were not audited and the provider failed to identify inconsistencies in the level of information in people's care plans to ensure staff understood people's needs. The provider also failed to identify that there was a significant lack of recording completed by night staff, as well as the provision of meaningful engagement with those people who were cared for in their rooms.
- We identified that risks to people's health and safety were not consistently assessed or accurately recorded and there was not always clear advice and guidance in place for staff to mitigate these risks and that people's consent was not always documented. We found that care planning was inconsistent and care plans lacked sufficient information to guide staff and ensure people's needs and preferences were met.
- For example, the provider did not identify areas for improvement in how safe care was provided. We found that medicines were not always managed safely and that nursing staff did not have their competencies assessed.
- The provider did not regularly audit health and safety concerns and during inspection, we found some poor infection prevention and control practices.

The provider had poor oversight of the service, did not have a consistent approach to quality monitoring and service improvement and leadership was not always robust. This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- Services that provide health and social care to people are required to inform the Care Quality Commission of important events that happen in the service. Notifications of this nature were submitted in a timely way

which meant we could check that appropriate action was taken.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Service user meetings were not facilitated which meant that people were not routinely involved in planning their care. However, people spoke positively about improvements brought about by the current manager. One told us, "[Manager] is cheery and always seems to have the time to say hello." A family member said, "This place seems to be better run now; previously it was difficult to know what was happening, I was told nothing." Another said, "As far as I can tell, staff seem highly motivated."

● Staff told us, "Now I feel so much more supported, this new manager comes in every morning. I feel valued in the work I do now." Another said, "[Manager] is good. They are very friendly and will just get into action. [Manager] has introduced some clearer systems."

● People's records evidenced a significant level of engagement with health and social care professionals.

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

●The provider and registered manager understood their responsibilities under 'duty of candour' to be open and honest when things went wrong, for example, notifying relatives if their family member had an accident or became unwell. We were told that there had been no incidents which met the duty of candour threshold.

● Family members confirmed that they were informed of all incidents and any health concerns concerning their relative.

● Staff knew how to whistle blow and told us they would raise concerns with the local authority and CQC if they felt they were not being listened to or their concerns were not acted upon.

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<br><br>Treatment of disease, disorder or injury | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>People did not always receive care that was person-centred. Care plans were not person-centered and were not always updated to reflect current needs. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Medicines were not safely dispensed; nursing staff did not have their competencies assessed. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Staff were not offered regular supervision and there was poor compliance with the provider's mandatory training programme. |

This section is primarily information for the provider

# Enforcement actions

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent |
| Treatment of disease, disorder or injury | People's consent was not always obtained before care or treatment was provided. |

**The enforcement action we took:**

We issued the provider with a warning notice.

| 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 | The provider had poor oversight of the service and failed to monitor and improve the quality of service delivery. Leadership was not robust. |

**The enforcement action we took:**

We issued the provider with a warning notice.