Avery Homes (Nelson) Limited

Clare Court Care Home

Inspection report

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Date of inspection visit:
19 September 2023
20 September 2023

Date of publication:
25 January 2024

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Clare Court Care Home is a nursing home providing accommodation, personal and nursing care to up to 80 people. The service provides support to older adults and people living with dementia. At the time of our inspection there were 61 people using the service. The home is split into three floors. The ground floor accommodates people who require residential care, the middle floor provides support to people living with dementia and the top floor accommodates people with nursing care needs. However, there were people on all floors living with dementia. Everyone had en-suite facilities in their rooms. People shared lounges and a separate dining area on each floor. There was also a communal garden area.

People's experience of using this service and what we found
The management team had not always investigated how serious injuries had occurred at the time of the injury. Risk assessments did not always provide enough guidance to robustly manage risks. Relatives of people receiving care and staff felt staffing levels were not always adequate. We found evidence of the inappropriate use of low-level restraint without assessment and guidance for staff. We saw significant improvements in medicines management.

People's care was not always person centred and did not always reflect their wishes. Monitoring and recording of food and fluid consumption for people at risk of losing weight was not adequate. People enjoyed the food served to them. We saw improvements in staff induction training and support.

We saw and heard evidence about examples of both poor and good practice with regard to promoting dignity respect and independence. We saw examples of staff not respecting people's privacy and not treating them in a dignified way. Some people and relatives told us staff were respectful of their privacy and dignity.

People and their relatives told us they felt there was not enough for them to do. This particularly impacted people who were mainly cared for in their rooms.

Systems to monitor the care people received and ensure they were safe and well, were not effective. Opportunities to learn when things had gone wrong had been missed.

People were not always supported to have maximum choice and control of their lives and staff did not always 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.

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 08 September 2022) 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 remained in breach of regulations.

Why we inspected
The inspection was prompted in part by notification of an incident involving a person who was using the service . The information shared with CQC about the incident indicated potential concerns about the management of risk of falls. This inspection examined those risks.

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

The provider has put together an action plan based on the concerns found at this inspection and has stated they are working to address all areas of concern. The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection.

Enforcement
We have identified continued breaches in relation to lack of personalisation of people's care, management of people's safety, staffing levels and deployment and systems and processes to monitor overall quality of care. We identified a new breach in relation to protecting people from the risk of abuse. We found the service was no longer in breach with regard to how it was supporting people in line with the Mental Capacity Act (MCA) 2005.

Please see the action we have told the provider to take at the end of this report.
Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not 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?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Clare Court Care 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 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
The inspection was carried out by 2 Inspectors, a Specialist Nurse Advisor and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Clare Court Care 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. Clare Court Care Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A new manager had been in post for 2 months and had submitted an application to register. We are currently assessing this application.

Notice of inspection
This inspection was unannounced. Inspection activity started on 19 September 2023 and ended on 12 October 2023. We visited the location on 19 and 20 September 2023.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. 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 sought feedback from the local authority and professionals who work with the service. We used all this information to plan our inspection.

During the inspection
We spoke with 10 people using the service and 11 of their relatives. We spoke with 13 staff, including the manager, regional managers, carers, senior carers, nurses, and housekeeping staff. We sought information from external professionals working with the staff team. We reviewed a range of documents including 12 care plans and other records of care monitoring. We looked at multiple medication administration records. We reviewed policies and procedures and quality assurance checks and documentation. We reviewed three staff files. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

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 requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management, Preventing and controlling infection

At our last inspection we found that risk to people had not always been assessed and mitigated. This was a breach of regulation 12 (Safe Care and Treatment) 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 12.

- At our last inspection we found records to monitor food and fluid consumption for people at risk of losing weight were not consistently kept. We found at this inspection such records were still inconsistent. For example, a person had been identified as having lost a significant amount of weight in recent months. Medical advice had been sought, but records of what they had eaten and drunk were not consistent. There was no record in some cases of action being taken when a person continued not to eat and drink well. This meant people remained at risk of further weight loss.
- At the last inspection we saw risk assessments did not always contain enough guidance for staff about people's specific health care needs. At this inspection we saw risk assessments for some people were not detailed or robust enough to mitigate future risk. For example, a person who had specific mobility needs had not had the associated risks fully considered. This left them at risk of possible harm.
- The provider was unable to evidence falls management procedures were always followed to ensure learning and prevent further possible falls. This left people at risk of avoidable harm.
- Systems to ensure people were checked upon to monitor their safety and wellbeing were not robust. Guidance for staff on how often people needed checking on was not always clear. Records of how often staff were checking on people were not kept. We saw some people who were able to use their call alarm did not have it in reach. This left people at risk of being unable to call for help when they needed it.
- We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. At our last inspection we found a carpet on the ground floor was odorous and had not been replaced in a timely way. At this inspection we found the same carpet was odorous, despite having been replaced. We also found carpets in other areas of the home, including people's bedrooms were odorous and remained so throughout the day. The management team described steps they had taken and had planned to address this. However, people were still exposed to possible contamination risk as well as the living environment being unpleasant for them.

Systems to assess, monitor and mitigate risk to health, safety and welfare of people using the service were not always effective. This placed people at risk of harm. This was a continued breach of regulation 12 of the

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
There was no limitation on when people could visit their loved ones. People and their loved ones were happy with the visiting arrangements in place.

Systems and processes to safeguard people from the risk of abuse
● There was no evidence to suggest some serious injuries had been investigated at the time they occurred. The management team were unable to provide evidence of how they had tried to identify the cause of some injuries. For example, a person had sustained a serious injury leading to fractures, the cause of the injury remained unknown. There was no evidence staff caring for the person around the time the injury was identified were spoken with for further information. Although there was no evidence to suggest the person had been the victim of abuse, a failure to investigate meant this possibility could not be excluded.
● The inspector shared their concern about the lack of evidence with the management team. The management team had not been in post at the time most of the serious injuries had occurred. The manager completed retrospective investigations into serious injuries when the cause was unknown. However due to the length of time since most of the injuries had occurred they had not gained any further information. Retrospective investigations were unable to identify the cause of some people's serious injuries and did not always share clear learning to prevent further risks.
● The management team had failed to share some serious injuries with appropriate funding commissioners at the time they occurred. This denied commissioners the opportunity to track, review and investigate serious injuries in a timely way.
● Systems to safeguard people from risk of harm from staff were not robust. For example, an allegation had been made against a staff member about their conduct. The investigation could not conclude definitively whether the alleged incident had occurred or not. Insufficient steps were taken to monitor the staff member even though the allegation could not be proven to be false. This left people at risk of harm.
● Systems to protect people from the risk of harm had failed to identify the use of restraint against a person living at the home. The manager and some staff did not have a clear understanding of what restraint can be, which had contributed to its use not being identified. Guidance for staff on how to support the person was not clear. The use of restraint had not been assessed as appropriate or safe. The manager investigated this concern. The investigation did not result in clear conclusions about the use of restraint and did not consider the possible risk of its use for others. This left people at risk of being inappropriately restrained.
● An authorisation of a Deprivation of Liberty safeguarding had expired for one person and had not been re-applied for. Another person's authorisation was due to expire within a week and had not been re-applied for. We also saw conditions on one person's authorisation had not been met. This left people at risk of being deprived of their liberty without legal authority.

Systems had failed to safeguard people from the risk of abuse and improper treatment. This placed people

at risk of harm. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we did not find evidence of concern about staffing levels or deployment. However, we did find staff had not received the support, training, and supervision necessary to carry out their duties. This was a breach of regulation 18 (Staffing) of the Health and Social Care act 2008 (Regulated Activities) Regulations 2014.

Although we saw improvements in staff support, training, and supervision at this inspection. We had concerns about the staffing levels and the deployment of staff. There was therefore not enough improvement made at this inspection and there was a continued breach of regulation 18.

Staffing and recruitment

● Relatives of people receiving care expressed concerns about staffing levels in the home. One relative told us, "They seem short staffed, they need more people." Another relative said, "I don't feel there are enough staff, they are pushed to the limit." One relative told us they had had to assist their relative with personal care on at least 2 occasions. They said this was because a carer had not been available for 15 minutes and their loved one was uncomfortable. Another relative told us they saw food going cold because there were not enough staff at mealtimes to support those who needed help to eat.

● One staff member we spoke with felt the staffing levels were sufficient, the rest told us they were concerned about staffing. One staff member told us they were assigned breaks but sometimes could not take them. They told us staff often called in sick and were not replaced. They said, "I think there is a problem we are short staffed… Sometimes if [people] fall on the floor, we don't know how long they have been on the floor."

● We saw people in the lounge areas when there were no staff to support them. We also found it difficult to locate a staff member on one occasion when a person wanted assistance. It took 18 minutes to find a carer who was free to help.

● Systems in place to help monitor staffing levels were not being used effectively. We saw the dependency tool used to calculate how many staff were needed. This did not accurately reflect the risks to some people. The manager explained due to short staffing they had not been able to analyse the call bell response times. There was no evidence other methods of assessing appropriate staff levels had been utilised, for example records of staffing observations. This left people at risk of harm.

● Recruitment systems only included one DBS check at the start of a staff member's employment. This is the minimum required by law.

Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. The provider had not taken steps to ensure staff remained safe to perform their roles after recruitment. For example, one staff member had been employed for 13 years. During this time no further attempt to assess their continued suitability and safety in their role had been made. This left people at risk due to lack of robust staff checks.

Systems to ensure people were supported by appropriately checked and safe numbers of staff were not robust. This placed people at risk of harm. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The manager explained that there were plans for staff to start completing annual self-declaration forms. These invited staff to volunteer any offences which may appear on their DBS since their first DBS check was completed. The management team later confirmed checks on call bell response times had been introduced

to help monitor staffing levels.

Learning lessons when things go wrong
● The service did not always manage incidents affecting people's safety well.
● A lack of timely investigation into some incidents and serious injuries meant learning opportunities were lost.
● Systems were in place to identify and share lessons learned but were not being used effectively.

Using medicines safely
● At our last inspection we found medicines management systems were not always robust. At this inspection we found significant improvements. We saw people were being supported safely and appropriately with their medicines. An electronic medicines management system (EMAR) was in place which flagged when medicines were due or late. A scanning in system for medicines helped prevent them from being administered incorrectly.
● Medical records showed people received their medicines when they needed them. Care plans gave guidance for staff on how people wanted to be supported with their medicines.
●There was appropriate guidance for staff on how and when to give 'as needed medicines.'
● Prescribed creams had clear guidance for staff on their use and they were labelled to show when they had been opened.

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

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Adapting service, design, decoration to meet people's needs

At our last inspection we found people's wishes and needs had not been fully assessed and adaptions to support people's needs were lacking. This was a breach of regulation 9 (Person Centred Care) 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.

● At our last inspection we saw little evidence people had participated in the development of their care plans. At this inspection the care plans continued to lack evidence of how people had contributed to their care plans and reviews. The information in care plans continued to be phrased 'about' people rather than by them.
● We saw during mealtimes some people were not offered a choice about what meal they wanted to eat. For example, a person living with dementia was given a meal without being asked if they wanted it. They were given no information about what the meal contained. Some people were not offered a choice about what they wanted to drink. People on soft diets were not offered a choice of dessert and were given yoghurt. On 1 floor everyone was given a cold drink in a plastic lidded beaker, whether or not they actually needed one. This was an unnecessary restriction and did not reflect people's needs or wishes.
● At the last inspection we saw on 1 floor people living with dementia were offered plated choices of meals. However, this was not consistent across the home. At this inspection we also saw some people living with dementia being offered plated options whilst others were offered no option at all. On one floor loud dance music was played through lunch in the dining room. People were not asked about what music they would like to listen to. The volume risked preventing people from being able to hear what was being said to them. Some people likes and dislikes were not taken into consideration.
● Although some people living with dementia had contributed to how their door was labelled, others had not had this opportunity. Some people living with dementia had memory boards to reflect their interests but others didn't. Some people's rooms were personalised to their taste, others were bare and devoid of decoration.
● Two relatives of people receiving care said they had participated in care reviews. The rest of the relatives we spoke with told us they had not participated. One relative told us, "There was a review prior to [their loved one] going in [to Clare Court Care Home] but nothing since."

People's needs and wishes were not always being considered in the provision of their care. People were at risk of their needs and wishes being neglected and disregarded. This was a continued breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we found staff had not received the support, training, and supervision necessary to carry out their duties. This was a breach of regulation 18 (Staffing) of the Health and Social Care act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements in staff support induction and training. However, concerns about staffing levels and deployment meant the service remained in continued breach of regulation 18 (Staffing).

Supporting people to eat and drink enough to maintain a balanced diet
● Some people who had experienced significant weight loss were not having their food and fluid consumption recorded or monitored consistently. This put them at risk of further weight loss. It was also difficult to determine whether people were eating well as records sometimes lacked detail. The quality of the food looked good. However, more work was needed to ensure people were offered choices and what they were offered and ate was accurately recorded when needed.
● Some people did not have access to drinks when they wanted them. For example, a person receiving care was heard shouting they were thirsty. An Inspector had to locate a staff member to provide them with a drink.
● Records did not always show people had been offered alternative options when they had declined food. Records also lacked information about whether snacks were offered to some people. We did see some people being offered snacks including fresh fruit during the inspection.
● People told us they enjoyed the food. One person told us, "The food is very nice, we get two choices for lunch." Another person said, "The food is good as a whole. I eat spicy food here that I never would have at home."
● We saw people were offered meals appropriate to their culture.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Although people received medical attention when it was needed, systems did not always ensure advice was followed. For example, a person who was at risk of choking had received all the appropriate referrals. However, advice for staff about what foods should be offered was not clear.
● People who had experienced significant weight loss, had received appropriate medical assessment. However, records had not always been updated with medical advice and did not always demonstrate effective monitoring of food and fluids.
● We saw evidence of people being supported to receive services from other health professionals. These included occupational therapy, chiropody and the speech and language therapy (SALT) team.
● Staff told us people received a good service from the local pharmacy. A relative of a person receiving care also told us antibiotics were collected on the same day the need for them was identified.

Staff support: induction, training, skills and experience
● Staff told us they received an induction; we received mixed views on how effective it was. Some told us they felt it was a good quality induction. Some staff said the trainer at the time of their induction had not been very good. They did add that the trainer who is now in post is much better. Staff who had had more recent inductions seemed to have more positive experiences, suggesting improvement in the quality of inductions.
● Staff gave mixed views about the support they received. Some said they had had recent supervision, some said they had not. One staff member told us, "we have supervision all the time. It's very useful." Another staff

member told us, "We have career development and advancement." However, another staff member told us, "I have never had an appraisal to tell me how I am doing." The new manager showed us a plan which was in place to ensure all staff had supervision and appraisals arranged.
● People we spoke with did not have concerns about the skills or experience of the staff team. Relatives of people receiving care gave mixed views. Some praised the staff. One relative told us, "Staff are very knowledgeable and have the right skills." Some relatives expressed concern about the level of training provided to support people living with dementia. One relative told us, "It doesn't seem there's enough dementia trained staff. I don't think they know how to treat dementia patients." This feedback was shared with the manager for their consideration.
● Staff told us they received regular training and refresher training. We saw overall compliance with the training was high for the staff team. There was little evidence of checks to monitor whether training was resulting in better care.

At our last inspection we found that the principles of the Mental Capacity Act 2005 (MCA) had not always been followed. This was a breach of Regulation 11 (Need for Consent) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Improvement has been made at this inspection and the service is no longer in breach of regulation 11.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

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

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.
● A re-application had not been made for one person's DoLS authorisation. Another person's application was due to expire and had not been re-applied for. We also found one person had conditions on their authorisation which had not been met by the service. We raised this with the manager who said this would be dealt with immediately.
● At our last inspection we found people did not always have their capacity assessed when needed. At this inspection we saw people had capacity assessments in place when required.
● At the last inspection we found best interests' decisions had not always been recorded about decisions taken on a person's behalf. At this inspection best interests' decisions were recorded for specific decisions. For example, one person had been identified as at risk of rolling off their bed. A bed rail could help keep them safe but is a form of restriction. The person was unable to decide for themselves about whether a bed rail was needed and the least restrictive option for them. A best interest's decision had been recorded to show why the use of the bed rail was in the person's best interests.
● Although there was some confusion amongst staff about what defined restrictive practice, they

understood consent and capacity. One staff member told us, "I believe all residents have some capacity, maybe some times more than others." Staff were able to tell us about the ways in which they sought consent from people and what to do if people declined support.

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.

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

- We saw a mixture of care approaches during the inspection. We saw a person being ignored by staff who were greeting and speaking with others receiving care. We saw some people left for long periods of time in their rooms with no evidence of when staff had been in to check on their wellbeing. We found some people in distress and in need of support but unable to attract the attention of staff from their rooms. We saw some staff were very busy and 'task' focused, with little time to stop and chat. We also saw examples of staff being patient and supportive.
- We saw adaptations for people with physical disabilities. One person commented staff do not refer to them by their preferred name.
- People we spoke with praised the staff team. One person told us, "The carers are very nice and helpful, very respectful." Another person said, "The staff are very good, whatever you want they fetch it from the shop. I like the girls, I know most of them."
- Relatives we spoke with generally spoke positively about the staff team. One relative said, "[The staff] always use [my relative's] name, they love [my relative] and hug them."

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

- We saw people were not always supported to express their views or to make decisions for themselves. We also saw examples of care staff being very respectful of people's views and wishes. For example, music was selected by staff without asking people what they wanted to listen to. A person was assisted to the dining room but not asked where they wanted to sit. We also saw a person who did not wish to be hoisted, staff respected their wishes.
- People told us about how staff supported them in the way they wanted. For example, one person said, "My door is left open at night, I prefer that." Another said, "The staff are nice and friendly. You get the odd one who I haven't had before, I give them my point of view and we come to an agreement."
- Staff told us they mainly worked in the same area of the home. This gave them the opportunity over time to get to know people well.

Respecting and promoting people's privacy, dignity and independence

- We saw and received mixed views regarding support for people's dignity, privacy and independence. There was clearly both room for improvement and examples of good practice. We saw some examples of people's privacy and dignity not being respected. Some people could also give examples of occasions when they had not been supported to maintain privacy. However, most people receiving care felt overall they were happy with the support they received to maintain dignity and independence.

● We saw a person had been dressed in a top which was missing buttons. Their under garments were showing as a result which was causing them distress. Care staff had not identified this. We saw some people being given drinks in plastic spouted cups when they did not need them. This was not a dignified approach.
● We saw examples of staff entering people's rooms without knocking first. We also saw examples of staff knocking people's doors but entering before they received a response. Some people also told us staff did not always knock before entering their room. This was not respectful of their privacy.
● Relatives gave mixed views about how people were supported with privacy, dignity and independence. One relative commented sometimes when they visited, their loved one smelt and clearly needed personal care. Another relative told us they had found their loved one was still in their night clothes at 11am. Other relatives told us they felt staff were respectful of people's privacy and dignity. One relative commented on how staff encouraged their loved one to walk to maintain independence.
● People told us about examples of support they had received. One person told us they liked to be private and felt this was respected. Another said, "[Staff] always knock and say who it is."

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 good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

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

● People were not provided with sufficient means to engage and stimulate them through the day. A small number of activities had been organised but people were left without occupation for long periods of time. People being cared for mostly or exclusively in their rooms were particularly impacted by a lack of activities. This left people at risk of isolation and deteriorating mental health.

● People told us they wanted more to occupy and engage them. One person told us, "I get lonely, there is never a lot to do." Another said, "I'd like to do more activities, they haven't got any. I just sit around all day."

● Relatives told us they were concerned people did not have enough to do. One told us, "I think they could do with more activities…. I see [my relative] there doing nothing, it is so boring. Another said, "[My relative] could do with more activities… I feel there is not a lot going on."

● We spoke with the manager about this. They acknowledged currently although there was an activity plan in place, it was not being followed due to insufficient staffing. They said there had been some recent issues within the team who provide people with engagement and activities which they had plans to address.

Improving care quality in response to complaints or concerns

● Although some relatives told us they knew how to make a complaint, the majority said they did not.

● Two relatives of people receiving care told us they had raised complaints and had not been happy with the response they received. They had felt their concerns had not been fully considered and taken seriously. One relative told us they were unhappy with delays in responding to their complaint. They said they had had to chase the service for a response.

● We spoke with the manager about these concerns. They told us they took people's complaints very seriously. They stated the delay in responding was not what people should expect but was due to the timing of the previous manager leaving the service.

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

● Care people received was not always in line with their personal choices and preferences. We saw examples of people not being given choices about their daily living. There had been an improvement in care plans but this didn't always lead to the provision of personalised care.

● At our last inspection, staff had difficulty navigating the electronic care planning system. At this inspection care staff told us they knew how to use the system and could find the information they needed.

● At our last inspection care plans did not always contain information about people's personalised needs. At this inspection care plans had more personal information. For example, in a pre-admission assessment we saw details of a person's pet, its name and who was caring for it. This could be used to reassure the person if

they were concerned.

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 were supported by staff who understood their communication needs. Where people were living with dementia and may struggle with verbal communication, staff understood and communicated in a dignified simple way.
● Staff were able to describe ways in which they tailored their communication to people's individual needs.

End of life care and support
● People's wishes about the care they wanted to receive at the end of their lives were recorded in their care plans.
● Staff received training to help them care for people at the end of their lives.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our last inspection we found that governance systems had failed to ensure risks to people's safety and wellbeing were identified and remedied. This was a continued breach of regulations 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Systems and processes to monitor health and safety were not effective. They had failed to enable staff to identify many of the issues noted during the inspection. Incidents and accidents had not been investigated in a timely manner. In some cases incidents and accidents were not shared with the funding commissioners as they should have been. This meant people were at risk of neglect and abuse and opportunities to learn from and mitigate risk were lost.
● The management team had failed to identify the use of low-level restraint on a person during personal care. Staff lacked guidance about how to respond to the person. The care plan was not detailed about how the person could be supported if they became distressed during personal care. An investigation was completed by the manager when the issue was highlighted by the Inspector. However, the risk to others who could become distressed was not considered in the investigation. This left others at risk of inappropriate use of restraint.
● Systems to monitor the safety and wellbeing of people had not identified the risks to people left for long periods of time alone in their rooms. Guidance for staff in care plans was not always clear about how often staff should check in on people. For example, one person's care plan stated staff should check on them 'very often.' This was not helpful or clear for staff. This left people, particularly those cared for in bed at risk of being left without care for long periods.
● Systems had also failed to help staff identify there was no recording mechanism in place for staff to show they had checked on a person. Guidance for staff on whether people could use their call bell was not always in the same place in the care plans. Monitoring of the safety of care provided had not identified people were in some cases left without a call alarm in their reach. This left people at risk of not being able to call for help when it was needed.
● Systems and processes to ensure people lived in a clean and hygienic environment had failed to ensure an odour free environment. A lounge carpet identified as odorous at the last inspection, remained odorous. Steps had been taken to try to address the issue but it remained a problem, leaving people at risk of contamination.

● Quality assurance systems had failed to ensure risks to people were reviewed in a timely manner to prevent further risks. Examples of failings to effectively monitor weight loss, choking risk, risk whilst mobilising and falls risks were all identified during the inspection. This left people at risk of avoidable harm.
● Systems to ensure people were supported by adequate numbers of appropriately deployed staff were not effective. People, staff and relatives felt the home was understaffed in some areas. This had not been identified or addressed by the management team, despite a number of unwitnessed falls in communal areas which had led to serious injury.

Systems and processes failed to ensure people received safe and appropriate care. This left people at risk of avoidable harm and abuse. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager ensured funding commissioners were updated regarding any incidents or accidents they had not been notified of. They advised that guidance for staff to promote safety would be updated. They told us additional training would be provided to staff to help them support people who can become distressed.

Continuous learning and improving care
● Opportunities to learn and improve when things had gone wrong had been missed.
● In some cases learning recommendations from incidents had been recorded but were vague. For example, after a serious injury, the previous registered manager had specified considering a safety aid as an action. It was not clear whether this had been introduced, or how it's effectiveness would be ascertained or reviewed.
● Systems were in place which could be utilised to share learning and good practice. However, at the time of the inspection they were not being employed effectively. This meant opportunities to improve people's care and safety and mitigate risk were lost.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● News about the home having a new manager had not reached everyone. Some people and relatives did not know who the new manager was. However, some relatives told us they had attended a meeting with the new manager. One relative told us the new manager's door was always open.
● Staff told us there were regular staff meetings which were not always well attended. Most staff told us the manager was approachable and listened to their concerns. Some staff felt concerned about a possible conflict of interests between the manager and another member of staff. A senior manager told us they would address this with the staff team, so they would know what to do if they had any concerns.
● Some people had participated in meetings to discuss the running of the home and how they would like it to improve.

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
● Not all opportunities to apologise when things had gone wrong had been taken historically by the management team.
● We did see more recent examples of more open apologies being offered to people and their relatives when their care had fallen short of what was reasonably expected.
● The manager was able to demonstrate their understanding of their duty of candour responsibilities. They told us they were committed to being open about when things went wrong.

Working in partnership with others
● Records sometimes showed although advice had been sought appropriately from medical professionals,

it had not always been shared or monitored effectively.

● People and relatives told us they received regular support from the local GP. One person told us, "The doctor sees me regularly."

● We saw evidence of people receiving support from the local podiatrist, occupational therapists, the tissue viability nursing team and the speech and language therapy team.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's needs and wishes were not always being considered in the provision of their care. People were at risk of their needs and wishes being neglected and disregarded.