St. Matthews Limited

Kingsthorpe Grange

Inspection report

296 Harborough Road
Kingsthorpe
Northampton
Northamptonshire
NN2 8LT

Tel: 01604821000
Website: www.stmatthewshealthcare.com

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Kingsthorpe Grange is a nursing home registered to provide care for up to 51 people living with mental health conditions and dementia. At the time of the inspection 46 people were living in the home.

People's experience of using this service and what we found
The provider failed to have sufficient managerial oversight of the service. There was a failure to implement and embed systems to monitor people's health and welfare and ensure all systems were in place to prevent and control the risk of infection.

People were at risk of undetected ill-health as staff did not complete clinical observations or recognise when people were showing signs of ill-health. People were at risk of not being referred to medical care in a timely way.

The provider did not have a system to monitor staff knowledge and skills in monitoring peoples' health, diabetes management, infection prevention and control, caring for people after a fall and safe nutrition and hydration.

People were at risk of choking and aspiration as staff did not have the information about people's dietary needs; staff did not always provide people with food and drink that safely met their needs. The provider's audits did not identify where people had not received food and drink that met their needs.

People were at risk of harm due to accessing areas with hot pipes, hot water and cleaning products. The provider's audits had not identified any health and safety or environmental issues.

People's belongings and personal records were not always stored securely. The provider did not have a reliable system to manage people's belongings or reunite people with their lost property when they had been found.

People who found it difficult to communicate verbally did not have the opportunity to communicate using other methods such as pictures or technology.

The provider's policies did not always consider the use of best practice guidance to provide sufficient information and guidance for staff to provide safe care.

The provider ensured there were enough staff on duty to provide care. There was ongoing recruitment in key roles.

People received their medicines as prescribed. Staff received training in managing medicines and their competencies had been checked.

People were protected from abuse as staff knew how to recognise the signs of abuse and who to report their concerns to. The manager had raised safeguarding alerts appropriately and worked with social workers to investigate concerns.

People and relatives had information on how to make a complaint. The manager had responded to complaints in line with the provider's policy. The provider used information from complaints to inform them how they could improve the service.

People's independence was promoted where possible. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

During the inspection the provider created a task force of personnel who visited the home on the second day of the inspection. The task force was deployed to assess, monitor and manage the changes required in health and safety, training and competencies of staff, updating audits, clinical practices, safeguarding and records. The provider supplied evidence if the immediate changes that had been made and their plans on how they were to implement systems and monitor these in the future.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Requires Improvement (published 22 July 2021).

Why we inspected
The inspection was prompted in part due to concerns received about the level of people's personal hygiene, nutrition, wounds and medicines. A decision was made for us to inspect and examine those risks.

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.

At the last inspection the provider was in breach of regulations relating to safe care and treatment and managerial oversight. We asked the provider to send us action plans to show what they were doing to implement and sustain improvements. The provider told us they would be compliant with these regulations by 30 September 2021.

At this inspection enough improvement had not been made and the provider was still in breach of regulations. We have identified five breaches in relation to safe care and treatment, staff training, nutrition, dignity and management oversight.

Please see the action we have told the provider to take at the end of this report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Kingsthorpe Grange on our website at www.cqc.org.uk.

Enforcement
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 will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

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 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?

Inadequate

The service was not 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.

Kingsthorpe Grange

Detailed findings

Background to this inspection

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

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
This inspection was carried out by two inspectors.

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

The service did not have a manager registered with the Care Quality Commission. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

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

During the inspection
We spoke with six people who used the service and two relatives about their experience of the care provided. We spoke with 17 members of staff including three provider's representatives, their safeguarding lead, clinical lead and human resources lead, the manager, one agency nurse, two senior care staff, six care staff and the cook.

We reviewed a range of records. This included 14 people's care records and multiple medication records. We looked at six staff files and three agency staff files in relation to recruitment, training and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at staff files, people's clinical information, health and safety data, quality improvement plans and staffing.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

At the last inspection the provider had failed to assess the risks to the health and safety of people using the service or take action to mitigate risks, and to ensure the safe administration of medicines had been completed. This was a continued breach of regulation 12 (2) (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.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- The provider failed to have systems to manage people's diabetes safely. Staff did not have enough information about people's normal blood sugar levels or know how often they should monitor these. Staff did not always check people's blood sugar levels before giving insulin. Where people had very high or very low blood sugar levels, staff did not closely monitor people at regular intervals; they did not take blood ketone levels or refer people to a doctor or diabetes team. This meant people were at risk of ill health due to undetected high or low blood sugar levels.
- The provider did not have a system to check on people's well-being and health following an accident or fall. People were at risk of undetected injuries or deteriorating health as staff did not take clinical observations or complete a body map of injuries at the time of the incident, or for regular periods afterwards.
- People were not protected from the risks of harm from hot pipes, hot water, cleaning products, soiled bedding and thickener. Staff had not ensured cleaning products were safely stored, or the sluice and kitchen was locked. Hot water pipes in bathrooms were exposed and radiator covers were broken, placing people at risk of being harmed if they were to touch or fall against these.
- The provider failed to ensure all fire safety procedures and checks had been carried out. The staircase which was a fire exit was being used for storage; this could hinder an exit in an emergency or be a source of fire. One person's bedroom door could not close as they had a picture frame attached to the door; this would not have provided the person protection in the event of a fire. People's emergency evacuation plans were not readily available in case of emergencies.
- The provider failed to implement a comprehensive and accurate handover for all staff. The handover available to staff was not accurate and did not provide all the information staff required, for example, people's mobility, dietary requirements and clinical information such as diabetes. This was particularly important as the service used agency staff.

Preventing and controlling infection;

● The provider failed to implement government guidelines for the early detection of COVID-19 symptoms which requires twice daily checks of people's temperature and the presence of a cough. Staff failed to take people's temperatures twice a day and there were no records of staff checking people for a presence of a cough. This placed people at risk of not being identified as having symptoms of COVID-19.
● The provider failed to ensure regular cleaning of frequently touched areas were carried out. We observed staff were not using appropriate cleaning products when cleaning frequently touched areas such as door handles. Cleaning records showed not all bedrooms were cleaned regularly and not all the allocated cleaning tasks in the rooms were completed.
● Staff did not have hand washing facilities available in the ground floor sluice as the sink was blocked.
● The provider's infection control audits failed to identify staff were not following government guidelines and cleaning was not taking place as scheduled.

The provider failed to assess the risks to the health and safety and doing all that was reasonably practicable to mitigate any such risks; Assess, prevent and control the spread of infections. This placed people at risk of harm. This was a continued breach of regulation 12 (2) (a) (b) and (h) (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the first day of inspection we informed the provider of our concerns. On the second day of inspection the provider carried out a health and safety survey and put a plan into action to improve the environmental issues. The provider reviewed the clinical safety and showed us how they planned to improve the systems for accidents and incidents, diabetes care, maintaining emergency equipment and identifying ill health.

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● 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 accessing testing for people using the service and staff.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Using medicines safely;
● People received their medicines as prescribed.
● Improvements were required in the management of creams which were stored in bathrooms, some were out of date, others did not have opening dates on them.
● Where people received their medicines covertly the provider had followed protocols involving health professionals. Decisions had been recorded to demonstrate covert medicines were required in people's best interests.
● Staff had received training and their competencies checked for safe administration of medicines.
● Staff followed the providers medicines policies and guidelines.
● The provider carried out monthly medicines audits and acted to improve where issues had been identified.

Staffing and recruitment
● The provider ensured there were enough staff on duty to provide care. However, there was a reliance on agency staff who did not always know people or their needs well.
● The provider was in the process of recruiting a deputy manager with clinical experience and activities staff. Agency nursing and care staff were used regularly to cover other vacancies.
● Staff were recruited using safe recruitment practices whereby references were checked and their

suitability to work with the people who used the service.

● The provider had a system and process in place to ensure Disclosure and Barring Service (DBS) checks were completed for all staff prior to them working with people. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse

● Staff had access to a safeguarding policy, however, it did not include all the information staff required to contact the local authority safeguarding team. We raised this with the provider during the inspection; they updated the safeguarding policy to reflect the updated information.

● Staff demonstrated they knew how to recognise the signs of abuse and who to report their concerns to. Staff had raised their concerns with the manager

● The manager had raised safeguarding alerts appropriately and worked with social workers to investigate concerns.

Inadequate

Is the service effective?

Our findings

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

At the inspection on 10 July 2019 this key question was rated as Good. At this inspection this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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

- The provider failed to have a system to ensure all staff knew of people's dietary needs. The handover information was inaccurate and incomplete which meant people were at risk of not receiving meals that met their dietary needs.
- The cook did not have information about each person's special diets. Where food had been ordered from the off-site caterers, consideration had not been made for people who required a pureed meal which was sugar free. This meant people living with diabetes who required a pureed meal were being given sugary puddings daily. This put people living with diabetes at risk of deteriorating health as a result of high blood sugar levels.
- The provider failed to ensure staff had information about people's current fluid requirements. Where people had been assessed by health professionals as requiring drinks with thickener so they could swallow safely, staff did not know what consistency people required. People's daily records showed staff were giving drinks with different consistencies to people throughout the day. This is placed people who required thickened fluids at risk of choking or a chest infection from aspirating on drinks that were too thin.
- The provider failed to have a system to monitor people's daily fluid intake. Although staff recorded what people drank, there were no daily targets set to know if people were drinking enough. This meant when people either stopped drinking or drank excessively, staff had not identified this. For example, one person living with diabetes showed signs of high blood sugar levels which made them thirsty, their records showed they had drunk excessive amounts. Staff had not identified this as an indicator of deteriorating health and had not referred the person to a doctor or diabetes team.

The provider failed to safely meet people's nutritional and hydration needs. This was a breach of regulation 14 (1) (meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- The provider had not ensured infection prevention and control training included the current government guidelines, and how to access these. This meant staff did not know to take people's temperature twice a day to help detect the early signs of COVID-19.
- The provider failed to ensure staff had the relevant skills, knowledge and competencies to assess, monitor and manage service users' diabetes, take clinical observations, monitor people following a fall or accident and ensure people received food and fluids which meet their dietary needs. This put people at risk of harm as people's health was not being monitored and deterioration in their health was not being identified in a

timely way.
● The provider failed to ensure staff had the skills and knowledge to know how to store and use cleaning products. This meant people had access to cleaning products which were known to be hazardous to health. People were at risk of infection from high touch areas that had not been cleaned with appropriate cleaning products.

The provider failed to ensure staff had the training and competencies to carry out their roles. This was a breach of regulation 18 (2) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The new manager had identified staff required additional training to assess and monitor people after a fall and had implemented training which some staff had received.

Supporting people to live healthier lives, access healthcare services and support; Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care
● The provider failed to ensure staff knew how identify when people's health was deteriorating. Where staff had taken clinical observations, staff did not identify when these were outside of the normal range and did not report these to a doctor. Staff did not complete a full set of clinical observations which meant they were unable to inform health professionals of an accurate picture of people's clinical health. This meant people were not being referred to a doctor in a timely way as staff did not recognise people were becoming very unwell, because of this people required emergency care.
● People did not always have access to equipment they required in an emergency as these were not always readily available or maintained in working order. One person could not have their oxygen levels taken as the pulse oximeter had run out of batteries. The suction machine was not regularly checked, and it was stored away. The defibrillator was not stored in its' housing. People were at risk of not receiving emergency care as the equipment was not readily available.
● The provider failed to implement systems which took onto account national guidance and standards on how to manage diabetes or monitor people for injuries after a fall. Staff did not have the information they needed so they could follow best practice such as The National Institute for Clinical Excellence (NICE) guidance on how to manage diabetes in a care home and how to monitor people for injuries after a fall. People were at risk of receiving care that was not in line with best practice.

The provider failed to do all that is reasonably practicable to mitigate risks to peoples' health and safety. This placed people at risk of harm. This was a continued breach of regulation 12 (2) (b) (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's risks of falls and pressure ulcers were assessed using evidence-based risk tools such as the Waterlow pressure ulcer risk assessment tool.
● Assessments were reflective of the Equality Act, considering people's individual needs, which included their age and disability.
● People had access to services such as opticians and chiropodists. One person told us, "I have my eyes tested, my teeth looked at and my feet done. If I need to the staff ring the doctor."
● The provider had found since the pandemic that people were unable to access a dentist for routine dental care; they had shared this information with the local authority. People who required urgent dental treatment had access to emergency dentist.

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

● Where people had relatives that provided belongings, people's rooms reflected their past lives and personalities. Where people did not have many belongings, their rooms were sparse.
● People had access to large communal spaces, quiet areas and a garden which were suitable for their needs.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

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

● The provider was following the principles of the MCA. People had been assessed for their mental capacity to understand the restrictions and procedures required during the COVID-19 pandemic; the outcomes of best interest meetings decisions had been recorded.
● The provider had submitted DOLS applications appropriately.

Requires Improvement

Is the service caring?

Our findings

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

At the inspection on 10 July 2019 this key question was rated as Good. At this inspection this key question has deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported;
- The provider had not ensured people had received care that supported them to maintain their health and well-being. The provider's policies and procedures had not taken into consideration best practice guidance, or ensured staff had the knowledge they required to manage people's needs safely.
- People's relatives had complained people's clothes and property had been lost. We found people's lost property such as watches, jewellery and glasses had been kept in an office without any indication of where or when these had been found. The provider did not have a system to always record people's belongings or trace the owner of lost items.
- Relatives told us before and during the inspection that people did not always wear their own clothes; when they visited, they found their relatives wearing other people's clothes. They also told us people clothes went missing.
- Not everyone had a duvet or warm bedding, some had just one blanket. People were at risk of being cold or uncomfortable whilst in bed as they did not have suitable bedding.

People were not always treated with dignity and respect. This is a breach of Regulation 10 (dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the first day of the inspection we raised these concerns with the provider. They set up a task force to begin making improvements on the second day of the inspection. This included ordering more bedding.

Respecting and promoting people's privacy, dignity and independence
- People's information was not managed or stored securely. Some people's post including bank statements were opened by staff and stored in files in the open office, which was accessible to all staff. There was no process in place to know who should manage people's post or to establish if people had the mental capacity to agree to their post being opened.
- People's and staff records were stacked in an open office and an unlocked sluice. These records were not filed in any order and some records dated back to the beginning of 2021. People's and staff privacy were at risk as these records had not been managed or stored securely.

The provider failed to maintain secure records. This placed people at risk of breach of their privacy. This was a continued breach of regulation 17 (2) (d) (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the first day of the inspection we raised these concerns with the provider. They set up a task force to begin making improvements on the second day of the inspection. This included the allocation of a member of staff from human resources to collate and manage all the records that had not been stored securely.

Respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care

● People told us staff were considerate. One person told us, "[Staff] wash and dress me. They cover me up for my dignity. The staff put my lipstick on. They know I like to wear this." We saw staff asking people if they would like protection for their clothes during meal-times.

● Permanent staff knew what people liked and preferred, this was from experience and was not always documented. One member of staff told us, "I have got to know people well. For example, [name] likes to get up early. They have pureed food and love ice-cream. Evening time they like to go to bed. A glass of water and call bell."

● Not all staff took time to provide personalised care. We observed two staff assisting people to eat their meals whilst standing. We spoke with one person being assisted to eat, they said, "I would prefer to have my meal in the dining room and staff sit down."

● People's independence was promoted where possible. One person said, "I try and help myself as much as possible. The staff do help me at times. I don't mind male or female staff. That does not bother me."

● People told us they were able to practice their beliefs and religion. On person told us, "I am Catholic and I can see a priest if I want to."

● The provider had implemented training for a dignity and respect champion network of staff within their organisation to help improve people's experiences of care.

Requires Improvement

Is the service responsive?

Our findings

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

At the inspection on 10 July 2019 this key question was rated as Good. At this inspection this key question has deteriorated 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 ; Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People's relatives visited the home; they were asked for information to demonstrate they had taken the relevant COVID-19 tests and their temperature was taken on arrival to the home to ensure they did not have any COVID-19 symptoms.
- People were assisted to access crafts and hobbies such as colouring when staffing levels allowed. One person told us, "I do the bingo here, watch TV and listen to music. I enjoy those."
- There were no dedicated activities staff employed. The provider told us they were planning to employ activities staff so there could be more regular activities that match people's past experiences and lifestyle.
- People's care plans did not reflect people had been involved in planning their care. The care plans did not include people's preferences, likes, dislikes or information explaining what was important to them. However, we observed, and staff told us people chose where to spend their time. One person told us, "I don't think I have seen a care plan or anything."

Meeting people's communication needs

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

- The provider was not meeting the requirements of the Accessible Information Standard. People living with dementia did not have access to information in mediums they could access. Staff told us they did not use picture cards or any electronic devices to help people to communicate their needs.

Improving care quality in response to complaints or concerns

- People and relatives had information on how to make a complaint. One person told us, "If I had a complaint I would go to [manager] the manager. She is lovely."
- The provider's complaints policy did not have the current information for the local authority. We brought this to the attention of the provider who updated the policy immediately.
- The manager had responded to complaints in line with the provider's policy.
- The provider used information from complaints to inform them how they could improve the service.

End of life care and support

- People's wishes and preferences for end of life care and support had not been documented. There was no record of whether end of life had been discussed with people or their relatives where appropriate. This

meant there was a risk people would not receive end of life care that met their individual needs or reflect what was important to them.

Inadequate

Is the service well-led?

Our findings

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

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

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

At our last inspection the provider had failed to have systems and processes in place to assess, monitor and improve the quality and safety of the service. This was a breach of regulation 17 (Good Governance) 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 17.

●The provider failed to identify their clinical systems had not been fully implemented. There was no system to monitor and maintain the emergency medical equipment. There was poor oversight of people's clinical observations and diabetes management which meant people were at risk of undetected illness and delays in medical care.
● The provider failed to have adequate systems to assess and monitor whether people's dietary needs were met. The provider's Nutrition Audit dated 12 November 2021 failed to identify people were not getting food and drink that met their needs. The provider's Nutrition and Hydration Guidance, peoples' care plans and daily handover did not give staff sufficient instruction or guidance to reliably ensure all service users received the correct consistency of food and drink to prevent the risk of choking or aspirating.
● The provider's policies and procedures did not take into consideration best practice guidance for staff to follow when monitoring peoples' health and well-being following an accident or fall, for infection prevention and for the management of diabetes.
● The provider's audits did not identify the environmental and infection control which placed people at risk of infection, exposure to cleaning products that were hazardous to health, access to areas with hot pipes and hot water and thickener. The fire safety procedures had not been followed as not all fire doors closed and the fire escape was used for storage.
● The provider did not have a system to monitor staff knowledge and skills in monitoring peoples' health, diabetes management, infection prevention and control, caring for people after a fall and safe nutrition and hydration.
● The provider failed to have a system to manage people's and staff records, post and belongings. The finance audit dated 19 November 2021 found financial records are secure, however, peoples' bank statements were not securely managed or stored.

The provider failed to have systems and processes implemented and embedded to assess, monitor and improve the quality and safety of the service, and assess, monitor and mitigate the risks relating to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a continued breach of regulation 17 (2) (a) (b) (d) (f) (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We met with the provider on the first day of the inspection and advised them of the issues we had found. The provider created a task force of personnel who visited the home on the second day of the inspection. The task force was deployed to assess, monitor and manage the changes required in health and safety, training and competencies of staff, updating audits, clinical practices, safeguarding and records. The provider supplied evidence if the immediate changes that had been made and their plans on how they were to implement systems and monitor these in the future.

- The service did not have a manager registered with the Care Quality Commission.
- The provider had understood the requirement to display their CQC rating and this was displayed in a communal area.
- Staff spoke highly of the manager, they all said they were supportive and approachable.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- The provider carried out a stakeholder survey in August and September 2021. The results of the survey had shown relatives had concerns about the communication and getting information about their relative's well-being. The provider had since employed a new manager and sent out information in a newsletter to staff about their plans to provide training to improve communication within the service.
- Staff had completed a training and development survey which the provider had identified further training in falls, dementia, and wound management were required.
- The provider informed staff by newsletters and alerts of any training and development initiatives, learning from incidents and recommendations from incidents within the organisation. Staff were invited to be champions in key areas such as dignity and dementia and join groups such as the patient safety group run by the safeguarding lead.

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 manager understood the need to be open and honest when things had gone wrong and remained open and transparent throughout the inspection. Records showed families were kept informed of any incidents or concerns with their relative.

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 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider failed to assess the risks to the health and safety and doing all that was reasonably practicable to mitigate any such risks and failed to assess, prevent and control the spread of infections.

The enforcement action we took:

We imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs
Treatment of disease, disorder or injury	The provider failed to safely meet people's nutritional and hydration needs.

The enforcement action we took:

We imposed conditions on the provider's registration.

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 failed to have systems and processes implemented and embedded to assess, monitor and improve the quality and safety of the service, and assess, monitor and mitigate the risks relating to the health, safety and welfare of people using the service. The provider failed to maintain secure records.

The enforcement action we took:

We imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure staff had the training and competencies to carry out their roles.

Treatment of disease, disorder or injury

The enforcement action we took:

We imposed conditions on the provider's registration.