Cornwall Care Limited

Blackwood

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This comprehensive inspection took place on 11 October 2017 and was unannounced.

The service was last inspected in March 2017. At that time we identified concerns in relation to risk management, medicines management and recruitment practices. The service was in breach of the regulations. Following the inspection the provider sent us an action plan outlining how they would address the issues highlighted in the inspection report.

Blackwood is a care home which offers care and support for up to 47 predominately older people. At the time of this inspection there were 43 people living at the service. Some of these people were living with dementia.

The service is required to have a registered manager. At the time of the inspection there was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe, and there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. 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 is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

People's risks were not safely managed at the service. One person had sustained an injury to their leg. This had been noticed by staff in the morning when they had assisted the person with a bath, but not reported to the district nurse service until the afternoon. When the person was seen by a nurse in the afternoon, staff were advised that the person should have had their leg elevated during the day to prevent further skin damage.

We found concerns relating to hazardous items in the environment. Kettles in the kitchenettes were accessible by people. Some people living at the service were physically mobile and had cognitive impairments. The kitchenettes were not always staffed. People were at risk of burning themselves on these appliances. We found that these had been used and were hot during the inspection.

We saw some positive interactions between people and staff. However, some interactions were concerning. Some people who called out repetitively were ignored by staff. This impacted on the people concerned and those around them who were becoming frustrated with the noise. Some people's privacy was not protected. Staff carried out care duties in a way that was not discreet. Staff did not seek people's consent before carrying out care duties or interact with people whilst assisting them. People's dignity was not always upheld. Some people were given the wrong clothing to wear. One person reported being given someone else's trousers which were clearly too big and fell down. People were not always treated with dignity and respect.

Where people expressed a wish to leave and live somewhere else, this had not been addressed by staff. Some people were seen to be distressed, asking for help or saying they were frightened. This was not responded to by staff.

People were not protected from the risks associated with cross infection. Parts of the service were visibly dirty. Bins in bathrooms and toilets were overflowing throughout the day. Cleaning schedules were inconsistently completed. There was a heavily stained carpet along one of the corridors which was very sticky. Staff told us it had been like this for some time. Furniture was stained with food ground into it.

People had minimal access to personalised activities. There was an activities coordinator, who worked part time, but activities were basic and more group focussed. The activity schedule on display was not accurate. People's care records contained minimal personalised information about the person's background, history, likes and dislikes. Staff did not always know the needs of the people they supported.

The service was not compliant with the Mental Capacity Act (MCA). An internal audit had highlighted areas of concern, which were being addressed. However, even in the records which had been reviewed, we saw concerns such as a lack of best interest processes and people and relatives consenting to elements of people's care without the correct legal authority to do so.

Feedback on the food was mixed. The lunchtime experience was not sociable. Tables were not laid with table cloths or condiments. Staff did not know what type of soup they were serving which meant it was not possible to offer people choice.

Staff training had lapsed in a number of mandatory subjects such as safeguarding, MCA and fire safety for a number of staff members. Staff told us they were not receiving regular supervision or appraisals. Recruitment practices were not safe. We saw an example where a staff member had not undergone all of the pre-employment checks required.

There was an inconsistent management team, with numerous managers coming into post, before leaving over the course of the past two years. Communication between managers and staff was poor. Staff did not know that a new manager had been appointed. People living at the service did not know who the manager was. Staff felt disempowered.

There was minimal opportunity for people and relatives to offer suggestions or provide feedback on the service. Residents' and relatives' meetings were not taking place. Staff meetings had started to take place, however staff told us that this had been inconsistent up until now.

People's medicines were generally safely stored, administered and disposed of. However, audits which were required to be undertaken daily were happening less frequently. We saw an example where a medicines error had not been identified as there was no audit on that day.

Some staff were kind and compassionate and committed to improving standards. We witnessed some examples of positive interactions between people and staff. Some staff shared appropriate humour and affection with people.

People had access to a range of healthcare professionals. There were comprehensive daily handovers. Kitchen staff were aware of people's health concerns and any dietary requirements

People and their families were given information about how to complain. There were quality assurance systems in place to make sure that any areas for improvement were identified and addressed. However, these had been ineffective and had not highlighted all of the issues raised in 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.

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 entirely safe.

People were not always protected against the risk of abuse or mistreatment because not all staff had received recent training in this area.

People were not protected from the risk of harm from hazardous items in the environment.

Infection control practices were not robust. Some areas were visibly dirty.

People were not always supported by staff who had undergone safe recruitment processes.

Is the service effective?

Requires Improvement

People's rights were not always protected because the principles of the Mental Capacity Act were not followed.

People's consent was not routinely sought by staff.

People and their relatives told us they did not enjoy the food.

People had access to a range of health and social care professionals.

Is the service caring?

Inadequate

The service was not caring.

Interactions between people and staff were not always caring.

People were not always treated respectfully.

People's privacy and dignity was not always protected.

Staff did not always know the needs of the people they supported.

Is the service responsive?

Requires Improvement

The service was not entirely responsive.

People's care records contained minimal personalised information.

People had access to some activities, however these were not personalised.

There was a system in place for receiving and investigating complaints.

Is the service well-led?

Inadequate

The service was not well led.

There had been a high turnover of managers at the service leading to inconsistent leadership.

There was a lack of communication and involvement from the managers to staff.

Staff felt disempowered and unable to raise suggestions.

Systems to monitor the quality of the service were not effective.

Blackwood

Detailed findings

Background to this inspection

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

This inspection took place on 11 October 2017 and was unannounced. The inspection was undertaken by two adult social care inspectors 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.

Before visiting the service we reviewed information we kept about the service such as previous inspection reports and notifications of incidents. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection, we looked around the premises. We observed the lunchtime experience and interactions between people and staff. We spoke with seven people who lived at the service and observed others who could not communicate their wishes and feelings verbally. We also spoke with four relatives. Throughout the inspection, we spoke with 13 members of staff and a visiting health care professional.

We looked at six records relating to people's individual care, training records for all staff, three staff personnel files, policies and procedures and a range of further documents relating to the running of the service.

Inadequate

Is the service safe?

Our findings

At our last comprehensive inspection in March 2017 we had concerns in relation to the management of identified risk. Guidance contained in risk assessments did not always reflect the actions being taken by staff to protect people. At this inspection we found that some risk assessments had improved. For example, people had up to date risk assessments in a number of areas such as falls, nutrition and pressure care. Despite this, we continued to have concerns in the management of risk at the service.

During this inspection, we saw that one person had injured their leg. During the afternoon, a district nurse came to examine the injury. Whilst the district nurse was doing this, a member of staff walked by and said that they had noticed the injury that morning whilst assisting the person to have a bath. The staff member said they had; "Not thought to report it". The district nurse advised that the person should have had the leg elevated during the day to prevent further damage and skin breakdown. Staff said they would take the person to their bedroom for bed rest. We were concerned that this injury was not reported when it was first identified that morning and that medical advice was not sought more promptly.

The service was arranged over two floors. Each floor had a dining and lounge area and kitchenette where drinks could be prepared. People were able to access the kitchenettes independently. We saw that people moved around the unit independently and that the kitchenettes were not always staffed. Many of the people living on the units had dementia. We saw hazardous appliances on these units such as kettles. We saw that these were in use throughout the inspection and were hot. This placed people at risk of burning themselves by using them unsafely, or from being injured should these items be used as a weapon. This was reported to the manager during feedback.

At the last comprehensive inspection in March 2017 we found concerns relating to medicines management. There were gaps in MAR charts and it was not always possible to know if people had received their medicines as prescribed. In addition there were no internal audits of medicines processes which may have identified some of the concerns such as gaps on MARs. At this inspection people generally had their medicines as prescribed and on time. People's medicines were stored and disposed of using the correct procedures. Where medicines required refrigeration, fridge temperatures were logged daily and fell within the guidelines that ensured the quality of the medicines was maintained. However, we found that medicines audits which should have been completed daily had been completed sporadically. We checked people's medicine administration records (MAR) and found an error which had not been picked up as there had been no medicines audit that day.

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

At our last comprehensive inspection in March 2017 we found concerns relating to recruitment practices. Two members of staff only had one reference on their file and we asked for the missing information to be sent from central office. They were unable to locate this and confirmed the references had not been received contrary to Cornwall Care policy. This meant recruitment processes were not effectively operated. The

action plan stated to us following this inspection, which detailed how the service would meet the requirements of the regulation stated that compliance would be achieved by adhering to the company policy and procedure. It also stated that HR (human resources) audits would check compliance.

Despite this, at this inspection we continued to find concerns. We saw an example where a member of staff only had one reference in their file. This meant the provider did not have satisfactory evidence of staff conduct in previous employment as specified in Schedule 3(7) of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014.

This was a continued breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found concerns relating to the cleanliness of the environment. Parts of the service were visibly dirty. For example, there was a carpet along one of the corridors which was very sticky and covered with large stains. We also saw chairs and other soft furnishings which were stained with food. One staff member told us; "The environment could be updated and chairs could be more regularly cleaned". Cleaning rotas were inconsistently completed for shared toilets and bathrooms and there was no cleaning rota for the sluice room, which was visibly dirty. One toilet was badly stained with faeces which remained there for several hours during the inspection. Many of the bins in toilets and bathrooms were overflowing with used tissues and paper towels. We reported these concerns to the manager. We were told that the carpet had been identified as an issue and was due to be replaced, however there was no date for this work to be carried out. We saw several doors marked as; 'keep locked' which were unlocked. These did not contain hazardous items.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not everybody living at the service told us they felt safe. One person was heard to say; "I'm frightened. I have never been so frightened in all my life." Another person approached us who was visibly distressed and crying and said; "Please help me. Can someone please take me? I have been in my room for hours and haven't seen a soul". Another person said, "I feel safe but not happy".

Although staff told us they would have no hesitation in reporting signs of abuse or mistreatment, we noticed gaps in mandatory safeguarding training for several staff members. This meant that they might not be up to date with current best practice in safeguarding adults.

Throughout the inspection, we observed suitable staffing levels. However when we asked people if they felt there were enough staff on duty to keep them safe, responses included; "At the moment, yes, but there aren't so many staff when it's cold because of sickness and "I think they need more staff, they look after me ok, but are stretched with others that need it." Comments from relatives included; "I don't think there are [enough staff], as some need care on a 1-1 basis, but there aren't enough here to do that" and "I suppose so, but when I'm in the lounge at times, there is no evidence of enough staff; if someone needs the toilet both staff are out of the room, so if you need anything you have to wait."

A maintenance person was employed full time at the service and they carried out daily checks to help ensure any defects were attended to. Staff told us they reported any faults to the caretaker and these were addressed promptly There were regular checks by this staff member to ensure the building was safe. People had personal, emergency evacuation plans in place (PEEPS) to advise services of the level of support they would require to leave the building in an emergency. Personal protective equipment (PPE) such as aprons

and gloves were available for staff and we observed them being used.

Incidents and accidents were reported to Cornwall Care's central office where they were signposted to the relevant departmental lead. These were analysed regularly so any patterns or trends could be highlighted.

Requires Improvement

Is the service effective?

Our findings

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 people lack mental capacity to take particular decisions, any decisions 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.

There had been a recent audit at the service which had identified significant issues with compliance with the MCA. For example, MCA assessments had not been completed where they should have been, some MCA assessments which had been completed were poor, Deprivation of Liberty Safeguards (DOLS) paperwork was out of date and staff were not up to date with MCA training. Managers were aware of these issues and had begun to review all of the MCA and DoLS records kept by the service and undertake new capacity assessments using a new online assessment tool. The new assessments and records were more comprehensive. However, even in the records that had been updated, there were no recorded best interest decisions. This meant it was not possible to understand what decisions the service had taken on behalf of others or to assess whether these decisions were in the person's best interest and the least restrictive available. We also saw an example where a person's representative had consented to elements of their care. However, we found that the representative only held a lasting power of attorney (LPA) for finance and therefore did not have the authority to make such decisions.

We found gaps in training records relating to the MCA and staff were unclear about how the Act applied to their practice. At lunchtime staff did not know what type of soup they were serving to people. This meant it was not possible to support people to make choices around their meals.

Staff did not routinely seek the consent of the people they supported prior to assisting them with tasks. For example, we saw staff members carrying out care or examining people without their consent. We also saw staff entering people's bedrooms without knocking and moving people without first gaining their consent or explaining where they were being moved to.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always supported by staff who had received training in order to carry out their role effectively. Staff had received training in areas identified by the provider as mandatory, such as safeguarding, moving and handling, fire safety and infection control and there was a system in place to remind them when it was due to be renewed or refreshed. However, we found gaps in training records for staff in areas including safeguarding adults, the Mental Capacity Act (MCA) and fire safety.

Staff told us they were not receiving regular supervision or appraisals. Comments from staff included; "Supervision? Not happening. Appraisal? Not happening" and "Supervision happens sometimes. I have been

here for years and I haven't ever had an appraisal". The manager told us; "Supervisions have lapsed, but we are very keen that staff do get supervision". There was a plan to address this with the creation of a supervision matrix and key roles for supervision responsibilities.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Newly employed staff were required to complete an induction before starting work. This included familiarising themselves with the organisation's policies and procedures and staff completely new to care were required to complete the Care Certificate.

We observed the lunch time experience. People were supported by suitable staffing levels to assist them promptly when necessary. However, we found that tables were bare at lunchtime. There were no table cloths or condiments to make the environment appear homely. Not all of the food appeared appetising. One of the options at lunchtime was a pie, however there were no vegetables or accompaniments with it. Feedback on the food was mixed. Comments included; "Yes, food's good, I like it," "I don't think I've ever had anything I don't like and if I did I could always ask for something different" and "Some meals better than others." Comments from relatives included; "Put it this way, I wouldn't eat it; He's a big eater and is always hungry; I bring food in for him and he's just eaten half a packet of biscuits straight after lunch" and "Food is ok up to a point." People's dietary needs were known by the cook and recorded in the kitchen. Any changes to people's dietary needs were communicated with the kitchen staff.

We saw from people's care records that they had access to a range of health care professionals including GPs, speech and language therapists (SALT), district nurses, and chiropodists. Throughout the inspection, we observed health and social care professionals attending to review people including a district nurse and a dementia liaison nurse. A new system called; "client of the day" had been introduced, which was a series of checks on two individuals per day. This included checking their skin integrity, weight, monitoring charts, medicines and food preferences.

We found that monitoring records were consistently completed so that it was possible to understand the care that was being provided and whether people's health concerns were being addressed appropriately. Advice from health professionals was linked to people's care plans. For example, where the person had had a SALT (speech and Language therapy) assessment and was required to follow a special diet, this was detailed in their records and known by kitchen staff.

People's bedrooms were personalised with personal belongings, soft furnishings and photographs and people's bedroom doors were personalised with their name and a picture. There were various areas in the building for people to spend their time including some quiet areas. There was a large garden to the rear of the property which staff told us was used regularly in the warmer weather. However, there was little within the environment to help people living with dementia to distinguish one area of the service from another, for example, different areas painted in different colours. There were also few sensory items such as rummage stations or reminiscence items for people living with memory impairments.

Inadequate

Is the service caring?

Our findings

Although some staff were kind and compassionate and committed to improving standards, interactions between people and staff were not always caring.

People's privacy was not always respected. We saw staff lifting a person's trouser leg to examine an injury. They did not seek the person's consent or explain to them why they were doing this. They continued to discuss the injury and how it had occurred without any interaction with the person concerned. The person's leg was treated and dressed in the shared lounge while other people were present.

We saw examples where people were not interacted with for long periods of time. An activity co-ordinator was employed and we saw they worked with other staff to provide an organised game for people during the afternoon. Not everyone was able to participate in this kind of activity due to their health needs and cognitive abilities. We saw little evidence of staff interacting with these people who were more difficult to engage with. During the inspection we saw some people sitting for long periods of time in lounge areas with very little to stimulate them. Other people walked up and down the corridors. We heard one person saying repeatedly; "I'm frightened. I've never been so frightened in all my life." We did not see any staff respond to this. Another person frequently made a high pitched noise throughout the day. Staff did not interact with the person or try and establish if they needed any assistance or support. We observed a staff member was sitting to the side of the person who was making the noise with their back to them. We heard other people lose their patience and shout at the person to, "Shut up." A member of staff responded saying; "She's not very well." They made no attempt to comfort the person or ask if they wanted to go elsewhere. The person was heard to make the noise for two hours during the inspection without staff intervention. When one staff member eventually responded to them, they smiled and stopped making the noise.

We spoke with one person and their relative who told us they were sometimes given other people's clothing from the laundry. They described one occasion when the person had stood up and their trousers had fallen down. The relative told us; "We had a look and they were a 42 inch waist! He's never had a 42 inch waist!" The person concerned was very slim. We were concerned the staff supporting the person to get dressed in the morning had either not noticed that the trousers did not fit or had not considered this to be important.

One relative visiting a person at Blackwood expressed that they did not like being separated from the person and would like to live with them again. There had been no arrangements made by staff to identify an advocate for the person to try and address this issue. We saw no evidence of referrals to befrienders for anyone living at Blackwood.

This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people and their relatives told us they were not happy at Blackwood House. One relative said; "No, he's not happy; he's very unhappy and wants to go home. He shouldn't be here, he has all his faculties and everyone and everything around him is getting him down." Another relative said; "She isn't happy here, she

doesn't like where she is upstairs, as lots of the women don't talk and others are too invasive and unwell, so she doesn't have much conversation."

Care plans contained very little detail about people's personal histories or background. This is important information as it can help staff to ensure people receive care in the way they wish and to engage with people by providing them with areas of interest for them to use in conversation. One person's care record stated that they; 'liked chatting to staff and watching TV'. There was no further detail about the person, their preferences or their background.

People were not given information in a meaningful way. There was little signage around the building to support people to move around independently and be confident about where they were. This is important for people living with dementia as the condition means people can easily become disorientated. There was a large menu board in the corridor with pictures of the meals on offer. However, menus in the dining areas were written on whiteboards with no accompanying pictures.

People were not asked for their views of the service or given an opportunity to express their ideas and suggestions. There were no arrangements for residents' or relatives' meetings in place.

People's specific needs were not always recognised or respected. Staff did not adapt their approach to people to suit their individual needs. For example, we saw a member of staff trying to draw round one person's hand as part of an activity. The person had limited movement in their hand and was unable to lay it flat. The member of staff was heard to ask the person to lay their hand flat.

Requires Improvement

Is the service responsive?

Our findings

People had care records in place however these were not always accurate. One person had come to the service from another care home. Much of their care plan still related to their care at the previous service. This had been identified as an issue by a recent audit undertaken at the service, but had not been addressed. Another person's care records indicated that they lacked capacity to make certain decisions, however a recent DoLS application had been declined as the person was found to have capacity. This had not been amended in the person's records.

There was limited personalised information in people's records, such as information about their background, history, likes and dislikes. One person's care record stated that they liked "watching TV and talking to staff" another person's record stated that they "Liked beauty". There was little further information to help staff gain a clear understanding of the person and what their preferences were or guidance for staff on how to work with them in a personalised manner.

Staff did not always know in detail the needs of the people they supported. One person's care records indicated that they had a diagnosis of depression which they had experienced for many years, leading to long periods of low mood. We specifically asked staff about this person and whether they had any mental health concerns. Staff we spoke with were not aware that the person lived with depression. We asked a staff member how they would get to know a person's needs. Their response was; "Good question!"

People had access to activities at the service, however these were basic and not personalised. For example, we saw staff engaging some people in a game of bingo. Not everybody was able to participate due to their physical or cognitive needs. These people were not being engaged with and remained in armchairs at the other end of the room. Others walked up and down the corridors. One person said; "I don't know where I am or what I should be doing". When we told this person there was a game of bingo in the lounge they said; "that sort of thing is not for me". There was an activity schedule displayed on the wall at the service, however staff told us this was not accurate. For example, on the day of the inspection, the schedule indicated that it was; "pamper day". We saw no evidence of this type of activity being offered.

There was a vehicle at the service, that accommodated four people. We were told that the activity coordinator had taken people out on trips, including a recent trip to the zoo, which they had enjoyed. However, as there was only one activity coordinator for the service, this meant other people had not had access to activities whilst others went out to these trips. The activity coordinator worked four days per week. On the other days there was nobody to undertake activities at the service. People and relatives told us there was not enough to do. One relative said; "There don't seem to be any activities; [relative's name] was knitting one day and staff were going to get her into doing more of that but nothing came of it. She does go into the communal lounge, but it's just not her environment as there's either Radio one playing or some programme on the TV that she has no interest in."

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

2014.

People had call bells in their bedrooms to alert staff if they required assistance. There were pressure mats to alert staff if people were out of bed, should they be assessed as needing support to mobilise. Throughout the inspection, we saw that if bells or alarms were triggered these were answered promptly by staff.

Daily handovers took place to help keep staff informed if people's needs changed and provide them with clear information. Staff kept daily records detailing the care and support provided each day and how people had spent their time.

There was a system in place for receiving and investigating complaints. Relatives confirmed they knew how to make a complaint and felt any concerns raised would be dealt with to their satisfaction. We saw that any concerns raised had been investigated adequately.

Inadequate

Is the service well-led?

Our findings

There were systems in place to monitor the quality of the service at Blackwood, however these systems had failed to identify or to or address in a timely way, many of the areas of concern identified at the inspection. This included concerns with risk management, infection control, staff training and supervision, recruitment, MCA and DoLS, people's records and with the way in which care was provided to people who were vulnerable. Medicines audits which were supposed to take place daily occurred sporadically, meaning that medicines errors were missed. We saw an example of this during the inspection. Where audits had highlighted areas of concern, these had not been addressed in a timely way. For example, we saw a comprehensive audit of the service which had highlighted numerous areas to be addressed and a target date for these to be completed by. We saw that the date had passed for most of these, without them having been addressed.

Despite the cognitive abilities of some people living at the service, there was access to hazardous items in the environment which could have caused serious injury. The systems in place to mitigate the risks were insufficient

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Blackwood is owned by Cornwall Care Limited. Cornwall Care Limited runs a number of services within the county of Cornwall. There is a clearly defined management structure and regular oversight and input from senior management. However, the management team at the service was not stable leading to inconsistent leadership. There had been several changes to the management of the service over the past two years. Some of whom stayed in post for short periods of time. This appeared to have impacted on the quality of the service, leading to poor standards in a number of areas. One staff member said; "The managerial changes have been hard work. There was a time when I could have walked out. I'll be happy when we get someone finally. There have been so many different approaches and practices".

There did not appear to be effective communication between managers, staff and people. At the time of the inspection, we were informed that there was a new manager, who had been in post for two days. This staff member had originally joined the service to undertake consultancy work, but had become the manager. Although we were told there had been a staff meeting in which this was discussed. Staff we spoke with did not know about this. Comments from staff included; "We are never told anything. We are not children" and "We don't get to know anything". This evidenced that the service did not always operate in an open and transparent way.

None of the people we spoke with who lived at the service knew who the registered manager was. When asked who the manager was, comments included; "'I don't know who it is," "No, I don't know who the manager is; I talk to all the girls" and "No, I've never seen them."

Staff told us they did not feel empowered to offer suggestions about the service. One staff member told us

they had visited another Cornwall Care home and had been impressed with the environment. For example, displays on the walls and the layout of the seating in the lounge areas. They had not felt able to raise these ideas with managers to be implemented at Blackwood. Staff meetings had not taken place consistently. When asked if there had been staff meetings, one staff member said; "Team meetings are variable. Dependent on the manager's outlook and what they consider to be a priority".

During the inspection, we noticed that staff engaged with some people and we saw some examples of caring interactions. However, we found that when people were more difficult to engage with, they were often not acknowledged or interacted with for long periods of time. There appeared to be a culture within the service where some people were routinely left to call out or walk around the corridors appearing disorientated or distressed, without attempts by staff to comfort or reassure them.

People were not involved in the day to day running of their home. There were no arrangements in place for relatives' or residents' meetings. There had not been a recent quality assurance survey which meant feedback on the service had not been formally sought.

There were systems in place to help ensure the environment was safe and well maintained. Staff recorded any faults or defects in a maintenance log and these were addressed by the maintenance person in a timely manner. Where they were unable to carry out the work themselves the fault was reported to head office. We found that the issue with the carpet had been identified and reported to central office, however it had not been replaced promptly.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not have access to personalised activities.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The principles of the Mental Capacity Act were not always followed and staff were not knowledgeable about the Act.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Premises and equipment were not always clean.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Checks to determine the suitability of employees had not always been taken.

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 10 HSCA RA Regulations 2014 Dignity and respect The principles of the Mental Capacity Act were not always followed and staff were not knowledgeable about the Act.

The enforcement action we took:

impose a condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Action was not always taken to manage risks to people within the service and medicines were not always safely managed.

The enforcement action we took:

positive condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance systems were not effective. Management of the service was inconsistent and weak.

The enforcement action we took:

impose a condition