Bondcare (London) Limited

Coniston Lodge Nursing Home

Inspection report

Fern Grove
off Hounslow Road
Feltham
Middlesex
TW14 9AY

Tel: 02088444860
Website: bondcare.co.uk/coniston-lodge/

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Coniston Lodge Nursing Home is a nursing home providing personal and nursing care to 92 adults. Most people were adults over the age of 65 years, some people were living with dementia and some were being cared for at the end of their lives. At the time of our inspection 48 people were living at the service. The service is managed by Bondcare (London) Limited, a private organisation.

People's experience of using this service and what we found
People were not always treated with dignity and respect. A small number of staff spoke about people, or behaved in a way which did not respect them. Other staff were kinder and more caring in their approach, but most of the time staff focussed on the tasks they were performing rather than the wishes and perception of the person being cared for. The registered manager had undertaken considerable work to improve this area since the last inspection, however we found there was not a consistent approach from all staff and as a result some people had a negative experience.

People's needs were not always planned for. Where specific needs had been identified, the staff had not always assessed and planned for risks or the care needed. Some care plans focussed on a list of standard tasks and did not include information about people's preferences. Where people had mental and physical health needs, these were not always recognised as a need, their safety and wellbeing had not always been assessed and there were no plans to support their wellbeing in this area.

People's social and emotional needs were not always being met. People using the service and their relatives told us there was not enough for them to do, with some people expressing loneliness. The provider employed an activities coordinator but they did not have the time or resources to ensure everyone's needs were being met and they were not assisted by other staff who spent their time meeting care needs.

There had been improvements in the way medicines were being managed, but people did not always receive their medicines as prescribed or in the correct way.

The provider's systems for monitoring and improving the quality of the service had not always been operated effectively. There were risks to people's safety and wellbeing which had not been mitigated.

The provider had recruited a new manager to the service since the last inspection and they had registered with CQC. They had started to make improvements at the service. They had introduced a number of systems for improving quality, but these had not been embedded at the time of the inspection.

Complaints, accidents and incidents were investigated and action was taken to learn from these.

There were appropriate systems for the recruitment, training and support of staff to make sure they had the information they needed to care for people.

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.

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 rating at the last inspection was requires improvement (Published 4 June 2019). We issued two warning notices and three requirement notices. We also asked the provider to send us monthly updates about the improvements they were making. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection not enough improvement had been made and the provider was still in breach of regulations.

This service has been rated requires improvement for the last four consecutive inspections.

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement
We have identified breaches in relation to person-centred care, dignity and respect, safe care and treatment and good governance.

We have imposed conditions on the provider's registration.

Follow up
We will request an action plan for 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

This service has been in Special Measures since 26 April 2019. As insufficient improvements have been made and there remains a rating of inadequate for the key question of well-led the service therefore remains 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 six months to check for significant improvements.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not 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 always well-led.

Details are in our well-Led findings below.

Coniston Lodge Nursing Home

Detailed findings

Background to this inspection

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

Inspection team
The inspection was conducted by two inspectors, an assistant inspector, a member of the CQC medicines team 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
Coniston Lodge Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We looked at the information we held about the provider, which included notifications from the provider, complaints, the provider's action plan and other information from members of the public. We used the information the provider sent us in the provider information return. This is information providers are

required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

We used all of this information to plan our inspection.

During the inspection
We spoke with 10 people who used the service, six visiting relatives/friends and staff on duty who included the deputy manager, nurses, care coordinator, care staff and the activities coordinator. We met with two of the provider's regional support managers who were offering managerial support whilst the registered manager was on leave. We observed how people were being cared for and supported. Our observations included 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.

We looked at the care records for 10 people, staff recruitment records for six members of staff, carried out a partial tour of the building, looked at medicines management and looked at other records used by the provider for managing the service, these included records of complaints and audits.

After the inspection
We asked the provider to send us some additional information about the service which we were unable to view on the day of the visit. We spoke with the local authority safeguarding consultant practitioner and representatives of the local commissioning authorities.

Requires Improvement

Is the service safe?

Our findings

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

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

Using medicines safely
At all the previous three inspections of the service, including the last inspection on 19 March 2019, we found that medicines were not always managed safely. This was a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that not enough improvement had been made and the provider was still in breach of Regulation 12.

● People did not always receive their medicines as prescribed. The relative of one person told us that the nurses sometimes gave them medicines to administer to the person in their food, if they had refused these medicines earlier in the day. There was no care plan or risk assessment in respect of this practice. The staff had not sought guidance or authorisation from a multidisciplinary team to make sure this practice was safe. This method of administration, including a difference to the prescribed time, had not been recorded.

Failure to ensure the proper and safe management of medicines is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had made some improvements to the way in which medicines were managed. Staff were trained and deemed competent before they administered medicines.
● Where people were prescribed 'as and when required' medicines there were protocols to assist staff to understand when to administer such medicines and how to assess whether they were effective.
● All medicines were available to be administered and there had been no out of stock items.

Assessing risk, safety monitoring and management
● The provider had not always assessed and planned for risks to individual's safety and wellbeing. A number of the care plans we viewed included reference to mental health needs, for example the plans included reference to, ''anger and frustration'', ''minor outbursts of physical aggression'', ''can be tearful at times especially in the evenings'', ''periods of anxiety and distress'', ''Stress towards [themselves]'' and ''can be aggressive.'' There were no risk assessments or care plans in respect of any of these needs or information to explain how the staff should support people to minimise the risks to their safety and wellbeing.
● Similarly, there were not always risk assessments relating to people's physical healthcare needs. For example, two care plans we viewed were for people with kidney diseases, one for a person with a condition which affected their breathing, one for a person who had a condition affecting their stomach and one for a person who was at risk of stroke. There were no risk assessments relating to these to inform the staff how

they should best support people to mitigate risks. The information was not incorporated into their care plans either. Another person's assessment stated they required ''slightly thickened fluids.'' There was no further reference to this in their nutrition and hydration care plan and the assessment did not quantify the exact consistency of fluids.

The lack of clear information about risks and how these should be mitigated meant that there was a possibility people would not receive safe care and treatment. This was a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 .

● The staff had completed assessments of risk regarding other needs for individual people. These included information about people's mobility and equipment needs. Some of this information was detailed and gave the staff a good guide about how to safely assist people to move.
● The provider took steps to maintain a safe environment. They carried out checks of health and safety, gas, electrical and fire safety. There were fire evacuation plans, including an individual plan for each person. The staff were able to tell us what they would do in an emergency situation or a fire. They had regular training and information about this.

Staffing and recruitment
At the previous two inspections including the last inspection of 19 March 2019, we found there were not enough staff deployed to meet people's needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a warning notice in respect of this.

At this inspection we found improvements had been made and the provider was no longer in breach of Regulation 18. However, people using the service, their visitors and staff all felt there were not enough staff to provide good quality care.

● Visitors we spoke with gave us examples about incidents where they felt staffing levels were not sufficient. These included an incident where a person fell asleep on another person's bed and the staff were not available to see this or respond to it causing the occupant of the room distress.
● We observed that staff did not spend time engaging with people. Their interactions were mostly task focused and once they had completed a task, they left the person. We saw people in lounges and their bedrooms for long periods of time without staff interaction or presence. People were also left alone in dining rooms when eating. This meant, whilst people's personal care and nutritional needs were being met, there was very limited social engagement or opportunities to meet their emotional needs.
● People did not have to wait for care and we saw that people were supported to take their time, so they did not feel rushed. During the inspection, call bells were answered promptly. Although the local authority commissioners who had audited the service in September 2019, found this was not the case on two days they visited. They identified that people sometimes had to wait for care and they told the provider about these findings.
● The provider had appropriate systems for recruiting and selecting staff. These included checks on their suitability, such as references from previous employers, information about any criminal records, checks on their identification and eligibility to work in the United Kingdom and an interview. Following successful recruitment, new staff completed an induction and had their competencies assessed to make sure they had the skills needed to care for people.

Systems and processes to safeguard people from the risk of abuse
● People using the service and their relatives gave us mixed views on whether they felt safe. Some relatives told us they were concerned about leaving the person at the service. Others told us they felt their relative's

safety depended on which staff were on duty.

● The provider had procedures regarding safeguarding adults from abuse and whistle blowing. The staff had received training in these and they were discussed at team and individual meetings. The provider had worked closely with the local safeguarding authority to alert them to concerns and to help develop protection plans following safeguarding alerts.

Learning lessons when things go wrong

● The provider had systems for learning from things that went wrong. The registered manager worked closely with other agencies to investigate concerns and analyse what had gone wrong. Information from these investigations was discussed with the staff team so they could share learning and make improvements together.

● The registered manager analysed all accidents, incidents and concerns monthly to identify any trends.

Preventing and controlling infection

● The provider had systems for preventing and controlling infections. These included providing staff with protective clothing, such as aprons and gloves. The staff received training regarding infection control. There were suitable arrangements for the disposal of waste. People using the service and staff were offered information about and opportunities to have vaccinations against flu.

● Domestic staff were employed to carry out laundry and cleaning of the environment. The service was clean and free from unpleasant odours on the day of the inspection and people told us they thought the service was kept clean.

● The provider carried out audits on cleanliness and infection control.

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

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- People's healthcare needs had been identified, but there were not always plans to show how these should be met. Where care plans listed a number of healthcare conditions, we found that there was sometimes no information about the support they needed with these, or risks associated with these.
- A recent audit by the commissioning authorities highlighted that essential healthcare checks, such as diabetic checks and Parkinson's checks, were not always undertaken in a timely manner. This meant that people may not be receiving the care and support they needed. They also felt the nursing staff they spoke with did not always
- People gave us mixed feedback about the quality of the food. But generally, people felt they had enough to eat and drink. There were a range of choices at each meal, and snacks available outside mealtimes. The staff offered people regular drinks, and jugs of water and squash were available in communal rooms and bedrooms throughout the day. The staff recorded people's food and fluid intake, and this was monitored by the nurses.

Adapting service, design, decoration to meet people's needs demonstrate an understanding about the importance of responding to changes in healthcare needs. For example, they identified a person's blood glucose levels were unstable, but there had been no response to this and the person had not been referred for specialist input from the healthcare teams. The commissioning authority had discussed their concerns with the provider.

The provider's failure to make sure people received personalised care to meet their health needs was a breach of Regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- There were regular GP visits to the service and the staff communicated people's needs to the GP. There were also dentists, chiropodists and physiotherapists who regularly visited people.

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

- The staff assessed people's nutritional and hydration needs and developed care plans where people were at identified risk. One person's family felt that the staff did not always follow their relative's care plan. We saw that the person's care plan identified them at nutritional risk and stated they needed to be supported and encouraged to eat. The family of this person told us they were often left and did not eat well and as a

result they had lost weight. The person's care records showed they had lost some weight.
● The provider was in the process of updating the environment and had plans for further work. They had installed new lighting and an improved garden area. At the time of the inspection, changes to the lighting had left the ceilings and walls in some units with some holes. Some walls and woodwork were marked or damaged. The provider's representative told us there were plans for these to be redecorated and new flooring laid. There were not many features to support people to orientate themselves as walls were mostly plain with a small number of pictures, photographs and signs. The provider was planning to update this and create a more dementia friendly environment.
● People were able to personalise their own bedrooms. The staff had also made efforts to create comfortable communal areas, with dining tables laid up nicely, flowers and matching accessories in lounges.
●There was a range of equipment, such as hoists, specialist baths and beds available at the service. Some of the bathrooms were out of order at the time of our inspection. The staff said they felt they had enough equipment however, some families commented that repairs were not always attended to promptly with one visitor telling us, ''We have been waiting for a long time for the lock on the toilet door and toilet seat to be repaired and the handle on the toilet to be seen to – they know it needs doing but nothing has been done.''

Staff support: induction, training, skills and experience
● The staff did not always communicate clearly or share information about people's needs. This sometimes meant they were offered care which did not meet these needs. For example, we witnessed a person being given a drink which they did not like. Their preferences had been recorded in their care plan, but the staff said that they did not have time to read this. Later another person was given a drink in a cup which was not suitable for them. On both occasions other staff intervened to correct the mistakes. However, the staff we spoke with told us the communication between the staff team was not always good. They said that mistakes like this regularly happened because the staff did not share the information and good practice they knew.
● The provider had improved the training and support opportunities for staff. All the staff we spoke with told us they found training useful and they were able to tell us about some of the good practice they had learnt. New members of staff took part in an induction, and their competencies were assessed by senior staff.
● There were regular meetings for individual staff and for staff teams, where they could discuss work and best practice. The registered manager had increased individual meetings with staff and carried out observations of their work and how they delivered care. The registered manager also ran workshops about specific topics with the expectation all staff would attend these to refresh their knowledge of key areas, such as safeguarding, dignity and team building.

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 authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● The provider had carried out assessments of people's mental capacity and made applications for DoLS authorisations when required. Information about the assessments, the DoLS authorisations and any conditions was included in the care plan.
● The staff we spoke with were able to explain the principles of the MCA and told us they had received training in this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The staff carried out assessments of people's needs before they moved to the home and then reassessed these needs at regular intervals. As part of the assessment process the assessor met with the person, their family and gathered feedback from relevant professionals.

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 last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence; Ensuring people are well treated and supported; respecting equality and diversity

At all the previous inspections including the last inspection of 19 March 2019, we found the staff did not always treat people with respect. This was a breach of Regulation 10 (dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a warning notice in respect of this.

At this inspection we found improvements had been made. However, Regulation 10 was still being breached because we witnessed incidents where staff provided task-based care which did not take account of people's individual experiences or wishes or show them respect.

- During the inspection, we witnessed a person calling for help. Two members of staff walked past their bedroom door (which was open) and did not respond. One of the staff members returned a short while later and entered the person's room. They did not speak with the person and instead started taking things out of their wardrobe. The person asked the member of staff who they were. They did not answer this and simply said that they would get the person dressed soon.
- In another incident, a second person asked for a drink. A member of staff promised to get this but did not return. After five minutes a member of the inspection team asked the staff member, in the presence of the person, whether they had got the person's drink. They responded by saying, ''The tea trolley will be here soon'' and walked away.
- The other interactions we witnessed between staff and people using the service were not unkind, but many focussed just on the task they were performing. For example, attending to someone's needs then leaving them without further conversation or reassurance. People were left without anything to do or anyone to talk with. This observation was also made by the local commissioning authority who carried out an audit over two days in September 2019. They also noted that people had to wait for their care because the staff were not available when they needed. People using the service and relatives commented that there was ''no atmosphere'' at the home and one person said they were made to live a ''solitary life'' and that they were frightened of ''living and dying alone'' at the service.
- One member of staff spoke about people they supported to the inspection team. They used terminology that did not show respect towards these people. For example, they called one person ''spoilt'' and another person ''rude.''
- Relatives commented that laundry items often went missing. The staff also told us that there were occasions when people were dressed in each other's clothes, including underwear.

Providing care which did not show people dignity or respect was a breach of Regulation 10 (dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People using the service felt that staff treated them with kindness but also commented that the staff were ''very busy'' and did ''not have time to talk'' with them. Relatives also told us the staff were kind, warm and welcoming. We observed a small number of staff who engaged with people in a friendly and sociable way. They made people laugh and comforted them when they needed reassurance.
● In response to the concerns raised at the last inspection, the provider had conducted individual supervisions about dignity and respect with staff and carried out observations to make sure they conducted themselves appropriately. These had been recorded with actions for staff where improvements were needed.
● The provider had introduced signs designed to alert others that someone was receiving intimate personal care and so they should not enter their room/bathroom. However, we saw that staff had sometimes left these signs on rooms where this was not taking place, which could be confusing.
● The provider had updated their audit of care plans to make sure these included reference to protected characteristics, such as sexual orientation, disability, race and religion. Some staff told us they shared the same cultural background, religion or first language with people they were supporting. They said that this enabled them to engage with people.

Supporting people to express their views and be involved in making decisions about their care
● People told us they were given choices by staff about what they ate and wore. But they could not recall being involved in developing their care plans. There was limited evidence to show that people had been involved in this process. Whilst some care plans recorded people's known likes and preferences, they did not demonstrate consultation with people or their families. Furthermore, the provider had a ''resident of the day'' process whereby they reviewed each person's care plan monthly. People and their families were not aware of this and had not been involved in these reviews.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

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

At the last two inspections we found people did not always receive personalised care which met their needs. This was a breach of Regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that not enough improvements had been made and the provider was still in breach of Regulation 9.

● People did not always receive personalised care which had been planned to meet their needs and reflect their preferences. Whilst the provider had taken steps to improve the format and way care plans were recorded, we found that some of these were not personalised. For example, one care plan we checked included a section about 'death and dying' which referred to a completely different person and their needs. This care plan had been reviewed by staff, but they had not recorded that they had noticed the error or made changes. One person's care plan stated they should always be addressed as their 'title' then 'surname.' However, their care plan and interventions recorded by staff also referred to them by just their surname and in some instances their first name. Two other care plans referred to people by either their middle or first names in different sections with no record to state which was their preferred name.
● Most of the care plans we viewed included generic statements rather than details about how the person wanted to be cared for or what their needs were. Where needs had been identified there was often no plan of care to meet these. For example, three people were recorded as having a ''fear of falling.'' There was no further mention of this in their care plans. Two of these people were assisted to move using a hoist, but the care plans relating to this did not refer to their fears or how they could be reassured.
● Other care plans referred to a range of emotional needs, such as anxiety, stress and aggression. There were no plans to state how the staff should meet these needs, and often the way in which the plans were worded indicated a lack of understanding about the person's needs by the assessor. For example, one person's care plan described ways the person could be aggressive. The plan went on to state there were ''no triggers [for this] – it is just [the way the person is].'' There was no indication that the person may have been trying to communicate distress or a need. There was also no plan for supporting the person with this.
● The provider's representatives told us that they had supported staff to have a better understanding of people's sexual orientation and identity. However, care plans did not indicate staff understanding. Care plans relating to sexuality included information about personal care needs, preferences for the gender of their care worker and in one case to ''keep [person] warm.''
● The provider had a process of ''resident of the day'' whereby each person was allocated a day for their

care plan to be reviewed each month. These reviews did not include consultation with the person or their family. We spoke with two people who were ''resident of the day'' on the day of the inspection. They were unaware of this, as were the care workers assigned to care for them.

The provider's failure to ensure that personalised care was planned and delivered was a breach of Regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● People were not supported to follow interests or engage in a range of social activities. Some of their comments included, ''I am bored, I sit here all day doing nothing, I would love a trip to the shops or outside'', ''There is never anything to do, I sleep a lot'' and ''It is boring, nothing going on.''

● Care plans did not include information about people's interests, leisure or social needs. Some included one or two sentences about a particular interest, although there were not any records to show they were supported with these interests. Throughout the inspection, most of the staff were involved in care tasks and did not spent time engaging with people. People were not given activities to participate in apart from colouring and sitting in communal rooms where music was playing. This was also the observations of the local authority commissioners over two days they visited in September 2019, and reflected in the feedback we received from visitors and people using the service.

The provider's failure to make sure people's social, leisure and emotional needs were met was a further breach of Regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The activities coordinator had recently returned to the service after a period of absence. They undertook individual activities with some people and spent time talking with them and getting to know their needs and interests. This was positive, but they were only able to support a few people each day. The deputy manager told us the provider was in the process of recruiting more staff to support with activities.

● The provider's representative told us that the registered manager had organised for a group of volunteers to improve the garden facilities. They had also organised for some special events and visiting entertainers. There were regular visits from a physiotherapist, and the activities coordinator told us they worked closely with this professional to make sure they supported people with exercises.

● People's visitors were welcome at the service at any time. Visitors told us they were able to be involved and support their relative if they wanted, for example, helping at mealtimes.

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.

● People's care plans included sections on hearing, sight and communication. People's individual needs and any additional support they required in these areas were recorded. The provider had produced some documents in different formats, although information for people about the service was not always presented in a range of different formats to help them understand this.

● The registered manager had developed cue cards to support people to communicate their needs and make choices about their care.

End of life care and support

● The staff worked closely with palliative care teams to make sure people received the right support at the end of their lives. This included pain relief, making sure they were comfortable and staff awareness about specific cultural requirements.

Improving care quality in response to complaints or concerns

● The provider had a suitable procedure for responding to complaints. People using the service, visitors and staff told us they felt comfortable approaching the registered manager with complaints or concerns. Those that had raised a concern, felt these had been responded to appropriately. There were records to show how complaints had been investigated, responded to and learnt from.

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 inadequate. At this inspection this key question has remained the same. 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.

Continuous learning and improving care
At the previous inspections of the service, including the last inspection of 19 March 2019 we identified the provider's systems for assessing, monitoring and mitigating risks and assessing, monitoring and improving the quality of the service were not always operated effectively. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that not enough improvements had been made and the provider was still in breach of Regulation 17.

● During the inspection, we identified that people's needs and the risks they were exposed to, had not always been planned for or mitigated. We also found that medicines were not always being managed safely. The provider's systems for monitoring the service had not always identified or mitigated these risks.
● The service has been rated requires improvement and we have identified breaches of Regulations at this and the previous three inspections. These Regulations remained unmet despite various action plans sent by the provider to tell us they would be making the necessary improvements. Therefore, the systems to improve the quality of the service have not been operated effectively enough to ensure that people received good quality care and support.
● We have taken enforcement action at the previous two inspections. However, the provider has failed to fully comply with this action, despite providing assurances they would.
● The service was placed in special measures following our last inspection. As part of our monitoring we requested monthly action plans and met with the provider to discuss how they would put things right. They had failed to make enough improvements since the last inspection. This meant that people were not always safe and did not receive good quality care.

Failure to operate governance systems effectively was a breach of Regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Despite the concerns we identified, we also recognised the provider had made some improvements at the service. In particular they had introduced additional checks and monitoring. The provider's own processes had also identified certain concerns. They had responded appropriately to accidents, incidents, complaints and safeguarding alerts, making sure they learnt from these.
● Some of the audits introduced by the registered manager included audits of dining experience, unannounced visits at night times and weekends, additional supervision, observations and assessment of

staff and care plan audits. These enabled the provider to assess the quality of the service. However, improvements had not been embedded at the time of our inspection.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● People gave us mixed feedback about the culture at the service. Some people spoke about individual staff who were kind. Their main concern was that the staff did not have time to sit and talk with them and some people felt isolated. One person told us, ''It is not very homely here.'' This view was echoed by visitors.

● The provider had introduced a new computerised system for planning and recording care interventions. The staff carried hand held electronic devices, so they could enter information about care given in real time. This reduced the need to spent time on written documents. It also meant that the provider could monitor people's care provision remotely to make sure their needs were met and have an overview of important indicators of their wellbeing, such as fluid intake.

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

● The provider had a policy regarding Duty of Candour. The registered manager and staff understood their responsibilities under this. We saw that where people had made a complaint, and when things had gone wrong, the registered manager had written to them to apologise. The letters explained the action they had taken to investigate and put things right, as well as expressing their apologies.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● The registered manager had started working at the service since the last inspection. They were experienced and had worked in similar settings previously. They were appropriately qualified. People using the service, visitors, staff and external professionals spoke positively about the registered manager. Some of their comments included, ''[Registered manager] is lovely, she is so calm and I feel supported'', ''If I had a problem I know the manager and I would talk to them'', ''We had some problems but in fairness the manager has been very proactive in dealing with them'' and ''She is good at telling us what is going wrong and if there is a problem.''

● The registered manager had a good knowledge of their legal requirements and good practice guidance. They had introduced new systems designed to improve and measure the quality of the service.

● The registered manager and senior staff at the service held daily meetings to discuss the service, any concerns, incidents and share information so they could provide consistent care to people.

● The registered manager had introduced a system of ''policy of the month'' where the staff familiarised themselves with a different policy each month. Recent policies had included data protection, safeguarding and nutrition.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The registered manager operated an open-door policy, and people using the service and their visitors told us they felt happy approaching the registered manager. There were also regular meetings for people and their visitors. These including sharing information about the service as well as providing information about dementia and other topics people were interested in.

● The provider sent out annual quality satisfaction surveys to all stakeholders in order to gather their views on the service.

Working in partnership with others

● The registered manager worked closely with other registered managers and senior managers within the organisation to share ideas and good practice. They also worked closely with the local authority safeguarding team and commissioners. They had regular meetings with the GP surgery and clinical commissioning groups to discuss the service.

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 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The registered person did not always ensure that care and treatment of service users was appropriate, met their needs or reflected their preferences. Regulation 9(1)

The enforcement action we took:

We have imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	The registered person did not always ensure service users were treated with dignity and respect. Regulation 10(1)

The enforcement action we took:

We have imposed conditions on the provider's registration.

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 registered person did not always ensure the safe care and treatment of service users. Regulation 12(1)

The enforcement action we took:

We have 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 registered person did not always effectively operate systems to assess, monitor and improve the quality of the service or assess, monitor and mitigate risks. Regulation 17(1)

The enforcement action we took:

We have imposed conditions on the provider's registration.