Benvarden Residential Care Homes Limited

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

Summary of findings

Overall summary

About the service:
Benvarden is a residential care home, providing personal care and accommodation. There were 12 people with frailty due to older age and / or dementia living at the home at the time of the inspection.

What life is like for people using this service:
• The provider had failed to act on fire safety concerns identified to them in a report sent from the local Fire Protection Team who inspected the service during April 2017. During our inspection we identified similar issues and shared serious concerns with the provider about risks posed to people due to inadequate fire safety.
• The provider's quality assurance system did not ensure quality and safety. The general décor and maintenance throughout the service was poor and posed risks of injury to people because repairs were required. This included repairs to masonry to prevent draughts in rooms, repairs to blinds where cords were broken and repairs to ensuites so that effective cleaning could take place and minimise risks of infection.
• Nationally recognised tools were not used to assess individual risks to people and risk management plans were inadequate.
• Medicines were not managed in a safe way and meant risks to people's health and wellbeing were posed.
• People were not always supported by staff that had the necessary skills and knowledge to meet their needs.
• People had detailed information in a one page 'pen portrait' about them, but this was not used to ensure people received personalised care. Throughout our inspection we found a lack of interaction and stimulation for people.
• People had plans of care, though these did not consistently include the information staff needed, such as information related to people's nutritional and hydration needs.
• There were insufficient staff on shift to safely meet people's needs and this impacted on people not being offered or supported with an afternoon drink or snack on the day of our inspection.
• Staff spoken with told us they felt they could telephone one another for support if needed or the provider, who also managed the home and spent four days a week in the service.
• There was no other managerial oversight of the home in the provider's absence and the provider's lack of effective governance meant the quality and safety of the service was poor.

Following our inspection, we notified relevant stakeholders such as the local Fire Service, Local Authority and Local Clinical Commissioning Group (CCG) about the areas of concern we identified.

We reported that the registered provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were:
Regulation 9 Regulated Activities Regulations 2014 - Person centred care
Regulation 12 Regulated Activities Regulations 2014 - Safe care and treatment
Regulation 17 Regulated Activities Regulations 2014 - Good governance
Regulation 18 Regulated Activities Regulations 2014 - Staffing

Rating at last inspection: The last report for Benvarden was published on 29 January 2018 and we gave an overall rating of Requires Improvement.

Why we inspected: This was a planned inspection based on the rating at the last inspection.
Enforcement: Action provider needs to take (refer to end of report). Full information about CQC's regulatory response to the more serious concerns found in inspections and appeals is added to reports after any representations and appeals have been concluded.

Follow up: Due to level of risks identified from this inspection, we wrote to the provider under Section 31 of the Health and Social Care Act 2008, to request an action plan to address our immediate concerns. We met with the provider at the service on 4 February 2019 to check they had taken urgent actions needed to ensure people's safety. We will continue to monitor progress made against the provider's action plan and any regulatory action as an outcome of this full inspection report.

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 so that there is still a rating of inadequate for any key question or overall, we will act 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. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will act to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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? The service was not safe. Details are in our Safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our Effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring Details are in our Caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our Well-Led findings below.	**Inadequate**

Benvarden Residential Care Homes Limited

Detailed findings

Background to this inspection

The 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.

Inspection Team: Two inspectors carried out this inspection.

Service and service type: Benvarden is a care home. People in care homes receive accommodation and personal care. 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 they; as manager, as well as the owner and provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection: The inspection was unannounced.

What we did when preparing for and carrying out this inspection:

We reviewed information we had received about the service since the last inspection. This included details about incidents the provider must notify us about, such as abuse. We also sought feedback from the local authority and professionals who work with the service. We assessed the information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During our inspection we spoke with three members of care staff, the cook, the housekeeper and the owner

/ provider and two visiting healthcare professionals. We spoke with three relatives and spent time with people living at Benvarden to see how staff supported them.

We reviewed a range of records. For example, we looked at six people's care records and multiple medication records. We also looked at records relating to the management of the home. These included systems for managing any complaints. We asked to look at the provider's checks on the quality of care provided.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm
Inadequate: People were not safe and were at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong:
• People were not safe as risks to them were not always being managed appropriately.
• There was a failure to ensure people were protected from the risks associated with inadequate fire safety systems and processes. One person's bedroom fire door was hanging off its hinges and could not be closed and the smoke safety strip was damaged. Other fire doors inside the home did not close properly. Most of the fire safety door guards which safely hold open fire doors were broken and staff had used plastic wedges to prop open fire doors.
• Fire safety routes were not safe. For example, a stiff bolt located high up on a front fire door exit posed potential delays in exiting the building. Other designated fire exits had bolts and security chains which presented hazards to a safe exit in an emergency. When we shared our concerns about fire safety at the service with the local Fire Protection Officer, they told us they had identified similar concerns which they had shared with the provider in April 2017. There was no evidence the provider had taken any action from their fire safety inspection and report.
• There was a failure to monitor gas boilers for potential carbon monoxide fumes.
• There was a failure to check windows had safety devices fitted to restrict opening. One first floor large bedroom window had no device fitted to prevent it opening beyond arm's length above the car park below.
• Staff had not always acted in response to environmental hazards which placed people at risk of injury. For example, one person's bedroom window sill had a sharp screw protruding from it. Staff had left a broken chair in another person's bedroom having placed a sticker on it saying 'broken'. However, it was questionable whether the person living with dementia would have understood the risks posed.
• The provider was responsible for analysis of accidents and incidents to identify patterns and trends and prevent a reoccurrence. Whilst staff had reported and recorded accidents and incidents, the provider had not undertaken an overall analysis to ensure risks of reoccurrence were mitigated. Staff told us one person 'often had skin tears on their leg because they pushed their leg down the side of their bed against the wall'. The provider had not taken any action to reduce risks of this person sustaining further skin tears.
• The provider did not use nationally recognised assessment tools to assess individual risks. Staff shared concerns with us about one person not eating and drinking enough, but we found no evidence of the provider sufficiently assessing this person's, or other people's, risk of malnutrition or dehydration.
• Where individual risks had been identified, people's plans of care did not consistently describe the action staff should take to minimise the identified risks. For example, in relation to the management of risks in relation to pressure care, mobility, diabetes or behaviour.

Staffing and recruitment:
• There were insufficient staff on shift to safely and effectively meet people's individual needs.
• A staff member told us they felt two staff on shift was 'too low' because six of the twelve people living in the home required support from two staff with personal care tasks. One staff member told us, "Six of the 12 people here need two staff to support them with personal care, so that can leave no staff in the building to

support others if the cleaner or cook has left and it is a day the manager does not work."
• During afternoon and weekend shifts, care staff also had non-care tasks to complete which meant they could not maintain observations of the communal areas / respond so promptly to people's needs for assistance. One staff member told us, "It's just two care staff on during the day and night. During the mornings, we have a cleaner and a cook, but in the afternoons and at weekends, one of the carers has to cover any urgent cleaning plus laundry tasks, plus the kitchen in the afternoons. It's not enough staff. One extra carer is what is needed."
• People gave us examples of having to wait for staff to be available to support them and during our inspection we observed example of the impact staffing levels had on people. For example, one person had to wait to use the toilet for over ten minutes because staff were supporting other people.
• The provider told us they did not use a recognised assessment tool to determine safe staffing levels required to meet people's individual needs.
• Communal areas of the home were unstaffed at times and people had no effective system to summon staff support if needed. One person had recently fallen in the lounge and staff told us they had been alerted by another person living at the service who recognised the person needed help. This person had shouted to staff who were supporting other people in other areas. The provider told us most people would not be able to use call bells due to living with dementia. However, care plans did not identify which people were unable to use call bells and there was no evidence to show other systems to alert staff to when people needed assistance.
• There was no clear responsibility for undertaking checks on people, for example, if they were cared for in bed and unable to use a call bell to request staff if needed.
• Two staff recruitment files looked at had gaps in the information relating to recruitment. Both files had no record of staff's interview, no start of employment date and no contract of employment. One staff student volunteer file looked at had no contract or volunteer role profile or any emergency contact details.

The above information meant the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection:
• Some parts of the home were not well maintained which meant effective cleaning could not take place. For example, most people's bedroom en-suites had tiles surrounding the sink that were broken and / or had gaps in grouting between the sink and wall join.
• There were risks of cross infection; new continence pads were stored on the floor next to toilets which posed risks of cross infection.
• There were no disposal sacks available for staff to use for soiled pads and no liner bags in clinical waste bins.
• The kitchen waste disposal bin was not foot pedal operated and was heavily stained from waste. Staff had to use their hands to open the bin which increased the risks of infections spreading.

Using medicines safely:
• The management of medicines was not safe and medicines were not always stored securely. For example, medicines that legally required additional safe storage were in a metal box, but this was not secured to a wall. Throughout our inspection visit, this metal box was not double-locked as required by the legislation.
• Neither the provider nor staff could tell us the safe temperature range for the medication fridge. On the day of our inspection the temperature showed 8.4 degrees and we shared concerns about the location of the medicines fridge being in the kitchen. Records were not kept by staff to evidence monitoring of temperatures took place to ensure people's medicines were stored safely and in line with manufacturer's instructions.
• We observed a staff member did not consistently follow safe practices when administering people's

medicines. For example, staff should sign people's individual medicine administration (MAR) record immediately after they had seen the person take their medicines. We saw three people's MARs were all signed at the same time later and not after individual administration.
• Staff did not follow pharmacy label instructions which put people's health and wellbeing at risk. For example, one person's eye drops had been opened on 27 November 2018, and the attached pharmacy label stated they needed to be disposed of 28 days after the seal had been broken. The eye drops were used on the day of our inspection visit and had been used for 36 continuous days after the date by which they should have been disposed.
• MARs did not always contain the required information. For example, one person required a medicine to be given three times a week but their MAR did not contain this information.
• Poor hygiene practices were observed when handling people's medicines. For example, one person's tube of tablets was emptied onto the medicine records folder so staff could count them. Staff used the same plastic pot for different people's medicines which posed risks of cross contamination.
• Staff had not recorded dates of opening on creams and lotions which meant they did not have the information needed to follow the manufacturer's instructions as to how long the product should be used once opened.
• Creams were stored in people's bedrooms and accessible. The provider
had not assessed whether people were at risk of accidentally ingesting these medicines or using them inappropriately.

The above concerns demonstrated a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse:
• The provider had undertaken or had copies of recently completed criminal record checks for staff and references had been obtained to check staff's suitability to work at the service.
• Staff had received training in how to safeguard people from the risk of abuse and were able to demonstrate some basic understanding of safeguarding principles. For example, they were aware if they noticed a bruise on a person they should report this to the provider. Care plans contained body maps which staff had used, for example, to record a skin tear.
• Relatives spoken with told us they felt their family members were protected from the risks of abuse by staff working at the service.

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.

Requires Improvement: The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
• People had pre-admission assessments before they moved in to live at the service. This included information around their medical history, mobility and nutritional needs. However, there were examples of when this information had not been transferred or used to inform people's plans of care. Two people's initial assessments referred to specific health conditions but these were not detailed in their plan of care, which staff did not have any knowledge of these.
• Needs assessments were not always updated to reflect people's current needs as their needs changed.

Staff support: induction, training, skills and experience:
• Staff received training through distance learning courses and an annual 'mandatory' training day. Some staff had obtained nationally recognised vocational qualifications. Relatives felt staff had the skills they needed for their job role and we saw safe and effective moving and handling skills were used by staff.
• However, the number of concerns identified regarding the care and support provided meant the training given was not consistently effective. We found poor practice in responding to the needs of people living with dementia, unsafe management of medicines and lack of infection prevention impacted on the quality and safety of care provided. One visiting healthcare professional told us, "Staff are more helpful than usual today because you (CQC) are here, they are trying to do things the right way, it's usually more lacksidasical."
• Staff told us they received individual supervision from the provider. No staff team meetings took place at all and a staff member explained this was because it was not in their employment contract to attend for these unpaid.

Supporting people to eat and drink enough with choice in a balanced diet:
• People were not offered or supported to eat and drink enough. Only three people had a glass of water accessible to them and during the afternoon, no one was promoted or supported to drink. At 4pm we asked a staff member about people not getting drinks and snacks and they responded, "There's only two of us on shift, we forgot."
• Staff told us they had 'concerns' about one person who had not been eating or drinking sufficiently during the previous four weeks. This person's nutritional care plan told staff to encourage and support them with eating and drinking. However, their eating and drinking risk management plan had 'N/A' (not applicable) entered which indicated this person did not have any nutritional risks. No food and fluid charts had been kept for this person and when we asked staff how much they had eaten or drunk over the past few days, no staff member could tell us. During the afternoon of our inspection visit, this person had a glass of water next to them. However, due to their frailty the person was unable to lift this themselves and no support was offered to them to drink from staff.

• Some people required their food to be pureed so it was soft enough for them to safely eat. We saw one person's lunch of egg, chips and gammon had been pureed together and was taken to them in a cereal bowl. This meant the person could not enjoy the separate flavours of the food. When we asked staff about the presentation, they told us, "We should puree foods separately but we don't."

• Lunch was not made an enjoyable experience for everyone to encourage them to eat. For example, we saw preparations for the lunchtime meal commenced well before lunch was served. The first person to be seated by staff at the dining room table for lunch sat there for over an hour and commented unhappily to us, "It will be teatime before I get anything."
• Some people told us they enjoyed their meals but others felt improvements could be made to ensure food was served hot. There was no mealtime choice because the provider had a set menu. However, staff said the cook would prepare an alternative if someone did not like something.
• Staff told us they monitored people's weights by measuring their mid-upper arm circumference. A new monitoring form had been put into people's care plans for 2019 but no information from 2018 had been transferred which meant there was no information to compare from previous measurements. The provider told us they did not audit people's weights. During our inspection visit, one person was visited by a healthcare professional after staff had shared concerns about the person's poor appetite.

Staff working with other agencies to provide consistent, effective, timely care: Supporting people to live healthier lives, access healthcare services and support:
• People had access to health care professionals. Staff gave us examples of when they would telephone for professional healthcare guidance.
• Two visiting healthcare professionals told us they believed staff followed their guidance. For example, when pressure-relieving cushions were supplied for people, staff ensured these were used.

Adapting service, design, decoration to meet people's needs:
• The service needed maintenance and redecoration in people's bedrooms and some communal areas. Bedroom furniture and furnishings supplied by the provider were worn, stained and some wardrobes were damaged and wobbled.
• People were unable to use the conservatory because it was not sufficiently heated.
• For people living with dementia, no assessments had been carried out to assess what alterations and adaptations, including suitable use of signage and decoration, were required to assist people to find their way around the home independently and provide the right environment for their well-being.

The failure of the provider to monitor and maintain the environment to an acceptable standard is further discussed in the well led domain.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA applications procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

• A staff member told us everyone had an approved DoLS but the provider later told us just one person had an approved DoLS and they intended to make an application for one person to restrict their liberty. This meant staff did not have the information they needed and may potentially have restricted a person's liberty without the legal authorisation to do so.
• Staff worked within the principles of the MCA and explained to people what was happening and gained their consent, for example, before repositioning them using a hoist.
• Relatives told us staff involved them in making decisions about their family member and their care. People's care plans recorded whether their relative had power of attorney. However, no copy had been requested by the provider to assure themselves relatives had that legal power.
• The provider operated Closed Circuit Television (CCTV) within the home and had cameras in corridors, the kitchen and all communal areas. The provider told us they gained consent for this live relay and stored recording from relatives when people moved to live at the service. A 'CCTV' sign was displayed in the front entrance of the home, but there was no information to inform people about who could access CCTV footage or the purpose of it.

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
Requires Improvement: People were not always well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Ensuring people are well treated and supported:
• We observed some examples of positive interaction between people and staff. For example, when a staff member supported one person with their lunch they gave encouragement and asked if they were enjoying their meal. One relative described staff as 'kind' and another relative said they felt 'staff knew what they were doing'.
• However, other staff interactions were limited and did not always demonstrate a caring approach. For example, one person asked a staff member what was for lunch and that staff member replied they did not know. The member of staff made no effort to go and find out so they could tell people. During lunchtime, there were no condiments on the tables and one person asked a staff member for some salt for their chips. The staff member did not reply and when the person asked again, the staff member failed to respond.

Supporting people to express their views and be involved in making decisions about their care:
• Relatives told us staff had involved them in their family member's initial assessment to inform their plan of care. People were given opportunities to share their life history, their preferences about things that were important to them.
• People had limited opportunities to make independent choices. One person told us they did not want to spend the day in their bedroom, but did not want to watch the television which was on in both parts of the lounge. The person was unable to use the adjoining quiet conservatory because it was too cold. Staff told us the conservatory was not used during the winter because the 'heating did not work properly' and this was the reason the conservatory was bolted shut.
• The provider informed us they did not offer people or their relatives the opportunity to attend 'resident and relative' meetings but if relatives wanted to talk with them, they could do so or with the staff on shift.

Respecting and promoting people's privacy, dignity and independence:
• Staff respected people's privacy and we observed staff knocked on people's bedroom doors before entering. A healthcare professional visited one person to take a blood sample. Staff asked the person where they would like this done so they had privacy.
• People's dignity was not always supported; there was a lack of maintenance, bedroom furnishings were worn and one person's bedroom door had the name of a different person on it. When we asked staff about this, they told us the name was of a deceased person and confirmed the current occupant of the room had lived at the home for 'over half a year'. Nobody had changed the name which was handwritten on a piece of adhesive tape attached to the door.
• Staff did not consistently show discretion when asking people if they wished to use the toilet. We witnessed a loud voice discussion between staff as to whether a person could be supported to the dining room table for lunch without using the toilet first and staff did not discreetly discuss or suggest this to them.

Requires Improvement

Is the service responsive?

Our findings

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

Requires Improvement: People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:

• People had individual care plans and relatives told us they had been involved in discussing their family member's plan of care.
• Care plans gave minimal information around people's holistic support needs and focused on their physical needs.
• Staff did not consistently meet people's physical needs. One person's finger nails had grown very long and made red indented marks into the skin on the palm of their hand. We pointed out this person's urgent need for nail care to the provider who requested staff address this during our visit.
• People's religious affiliation was recorded, but there was no information about how important it was to them.
• Where people had specific health conditions additional information was not consistently provided to tell staff how they should ensure needs were met. When we asked staff about one person's health condition they were unaware of it or of any adjustments to the person's diet that might be required.
• There was little sign of any meaningful activities taking place according to people's assessed wants, needs, wishes and preferences.
• Care plans contained a detailed 'pen portrait' about people's interests and hobbies, however, people's individual needs for social stimulation, community inclusion and access to group activities were very limited. Planned activities were limited to a Wednesday morning when an extra staff member was allocated to the shift or facilitated by student volunteers or to 'ad hoc' entertainment.
• We observed a volunteer do some art with two people for one hour, however, no other activities were offered by staff throughout the day. Two televisions were on showing the same programme in the open plan lounge and of the 10 people, only one told us they were watching it. Another person told us, "It's better than nothing but I'm not interested in it." People told us there was not enough to do. One person told us, "I am bored."
• We found a lack of interaction and stimulation for people outside the delivery of care tasks and limited opportunities for people to engage with staff or each other. When staff supported people with care tasks, such as transferring people, staff had a friendly approach and explained what was happening.
• We asked a staff member about activities for people living with dementia, they told us they had previously purchased 'puzzle items' but these had been broken. There were insufficient skilled staff on shift to offer people personalised care that met their individual needs or focused on their abilities and interests.
• Information was not available in an accessible format to people and the provider told us they were unware of the 'Accessible Information Standard' (AIS). For example, the provider's complaints policy was only available in a written format. The AIS aims to make sure that people who have a disability, impairment or sensory loss get information that they can access and understand and any communication support they need.

The above concerns demonstrated a breach of Regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulation 9. Person-centred care.

Improving care quality in response to complaints or concerns:
• The registered manager told us they had not received any complaints.
• People using the service and their relatives did not give examples of any complaints made or an indication they planned to make a complaint. Relatives, overall, gave us positive feedback telling us staff were nice. People living at the service gave us mixed feedback and commented on where they felt improvements could be made to the service but did not feel they wished to make a complaint. Comments related to their lunchtime meal being cold, wanting things to do and having to wait for staff to support them.

End of life care and support:
• People had 'ReSPECT' assessments, where decisions had been made to 'Do Not Attempt Pulmonary Cardio Resuscitation' (DNACPR).
• Care plans contained a section for information about people's end of life wishes and preferences, but information was limited to funeral director arrangements or a person's next of kin.
• Staff told us one person was receiving end of life care, but their care plan gave no information about this and staff told us this person had been 'stable' for 'about nine months'. We recommend that the provider seek advice and guidance from a reputable source in relation to care in line with best practice; 'The Priorities of Care for the Dying Person'.

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
Inadequate: There were widespread and significant shortfalls in service leadership. The provider and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

• The provider's governance systems in place to monitor the quality and safety of the service were inadequate and did not identify the shortfalls we found. Risks related to people's safety and welfare in fire safety, medicines management, infection control, maintenance of the building, and the insufficient numbers of skilled and knowledgeable staff, available to meet people's needs at all times had not been identified.
• We found shortfalls in the accommodation, which included the maintenance of the building, its fixtures and furnishings. The lack of safe and suitable facilities had a direct impact on people, which risked their safety, health and welfare and posed risks of cross infection. For example, one person had inserted tissues into cracked masonry around their bedroom window to block cold drafts. Some of the provider's furniture, fixtures and fittings were damaged. Seals around sinks and cracked tiles prevented effective cleaning. A lack of oversight had resulted in the fire risk assessment not being accurate, and confusion from staff and the provider about the evacuation process. The provider had not identified or acted on areas that required improvement in a timely way.
• The provider delegated checks of the service to senior care staff. However, these checks were not recorded and the provider had not undertaken their own audits.
• Observations of staff practice were not in place. For example, the provider told us they did not undertake spot checks of staff care practices to assure themselves safe and good care was consistently given to people. There was no system used to record observations of staff to ensure they safely administered medicines to people.
• Staff were not suitably supported by the provider. On the provider's three days off each week, there was no managerial oversight or support to staff. One staff member told us, "There is no formal on-call rota, we just phone the senior carer who was on shift last. We have the manager's number so could call them."
• There was no system in place for auditing the premises and health and safety checks of the service. Staff they told us broken radiator covers things had been broken for 'ages' but there was no reporting system in place for staff to log repairs needed and no one to telephone to arrange maintenance repairs. We identified shortfalls over looked by staff and the provider because effective checks and audits were not undertaken.

Managers and staff are clear about their roles, and understand quality performance, risks and regulatory requirements:
• The owner / provider was also the registered manager of the service. They work at the service four set days each week and in their absence, there was no managerial oversight. The provider told us their senior care staff were experienced, and most shifts had one senior care staff member as one of the two staff members on the shift. The provider and the senior care staff who had delegated responsibilities for checks did not consistently understand their roles relating to quality performance, risk management and regulatory requirements.

The above concerns demonstrated this is a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014

• The Commission requires registered providers to report important information and incidents to us in a timely way. We noted from the records reviewed we had received information as required.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics:
• The provider had undertaken a quality assurance survey in January 2019. All 12 questionnaires had been completed by people living at the service, or their relatives. The results recorded a satisfaction rate of 83-100% in all aspects of the service. The level of satisfaction reported on by people and their relatives was not reflected by our findings during our inspection visit.
• The provider did not facilitate opportunities to staff to share their views about the service because staff meetings were not arranged.

Continuous learning and improving care:
• The provider told us they did not attend local care provider meetings, workshops or update themselves with the Care Quality Commission provider newsletter. There was no evidence to show how the provider assured themselves of what good dementia care was or how they kept themselves informed of current best practices.
• Due to the level of risks identified from this inspection, we wrote to the provider under Section 31 of the Health and Social Care Act 2008, to request for provision of an action plan to address our serious concerns.
• We met with the provider on 4 February 2019 so they could show us what immediate actions they had taken to ensure people's safety and wellbeing were maintained at the service. We will continue to monitor progress made against this action plan and any regulatory action as an outcome of this full inspection report.

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 People did not receive appropriate support that meet their needs or reflected their preferences.

The enforcement action we took:

Notice of Proposal to 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 The provider did not adequately assess and protect people against risks by doing all that is practicable to mitigate any such risks. A lack of risk management related to the management of the premises, fire safety, medicines management and infection prevention.

The enforcement action we took:

Notice of Proposal to Impose a Condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that robust quality systems or processes were fully effective to monitor the service appropriately, including people's safety.

The enforcement action we took:

Notice of Proposal to Impose a Condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured there were always sufficient staff with the skills and knowledge

needed to meet the requirements of their roles.

The enforcement action we took:

Notice of Proposal to Impose a Condition