MMCG (2) Limited

Blenheim Care Centre

Inspection report

Ickenham Road
Ruislip
Middlesex
HA4 7DP

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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
Blenheim Care Centre is a residential care home providing personal and nursing care for up to 64 people. At the time of the inspection 54 people were living at the service. The provider offers a service to younger adults with disabilities and older people, some of whom were living with the experience of dementia. The home is divided into three units. The ground floor provides accommodation to the younger adults and some older people. The first floor is for people who do not have nursing needs but have dementia and the second floor is for people with dementia and nursing needs.

The service was owned and managed by MMCG (2) Limited, part of the Maria Mallaband Care Group, a private organisation providing care services in England.

People's experience of using this service and what we found
People were not always safe at the service. Risks to their safety and wellbeing had not always been assessed or planned for. Some of the information about people's needs was inaccurate and staff did not always follow the guidance from healthcare professionals. This placed people at risk of harm. There were also potential risks within the environment which had not been assessed or mitigated.

Medicines were not always being managed safely.

The provider did not always investigate or respond adequately to concerns about people's safety and wellbeing to rule out the risk of possible abuse. Where investigations had taken place, there was not always learning from these to make sure improvements were made.

People's needs were not always planned for or met in a personalised way. Care plans contained generic information which did not always specify people's needs or preferences. The care being provided was often task based and this meant people did not have the opportunity to engage with staff or make choices about their care. Some of the staff treated people disrespectfully.

The provider's systems for monitoring and improving the service had not always been operated effectively, because they had failed to identify or take action where regulations were not being met.

People using the service and their visitors told us they were happy with the service and the staff, they felt able to raise concerns and speak with the registered manager. However, they felt that improvements regarding the food and social activities were needed.

The staff told us they felt well supported and enjoyed their work. However, we found that the staff were not always knowledgeable about their work or the needs of people who they were supporting. Records of meetings with the staff did not address areas of concern about practice or adverse events at the service. Furthermore, where staff had raised concerns during individual meetings with their line manager, there was

no record to show how these had been addressed.

There had been some improvements at the service, in particular there was now a more permanent staff team. There had also been improvements to the environment, and more were planned. People using the service, visitors and staff found the registered manager supportive and responsive.

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 last rating for this service was requires improvement (published 20 December 2018) and we identified breaches of regulations relating to person-centred care and good governance. The service had also been rated requires improvement for the previous two inspections. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection, we found not enough improvement had been made and the provider was still in breach of these regulations. We also identified breaches of three other regulations relating to dignity and respect, safe care and treatment and safeguarding people from abuse and improper treatment.

Why we inspected
The inspection was prompted in part due to concerns received from the local authority regarding the leadership of the service and the provider's failure to identify and respond to safeguarding alerts. A decision was made for us to inspect and examine these areas as well as looking at whether they had made improvements since the last inspection in all areas.

We have found evidence that the provider needed to make improvements. The overall rating for the service has changed from requires improvement to inadequate.

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

Enforcement
We have identified breaches in relation to person-centred care, treating people with dignity and respect, safe care and treatment, safeguarding people from abuse and good governance.

You can see what action we have asked the provider to take within our table of actions.

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.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration,

we will re-inspect within 6 months to check for significant improvements.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Blenheim Care Centre

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
Blenheim Care Centre 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 all the information we had received about the service, which included feedback from the local authority about concerns they had. We looked at notifications, safeguarding alerts and information from members of the public we had received. We also looked at the provider's action plan following the last inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service

does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with 20 people who used the service and nine visiting friends/relatives. We also spoke with a visiting healthcare professional. We looked at the care records, or part of the care records for 15 people using the service. We looked at staff recruitment files for six members of staff, records of team meetings, handovers, supervision meetings and staff training records. We also 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 inspected the environment and equipment being used. We also looked at how medicines were being managed.

We met and spoke with the registered manager and staff on duty, who included the deputy manager, care workers, senior care workers, nurses, activities staff and the provider's quality assurance manager.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Inadequate

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management

● The risks to people's safety and wellbeing were not always assessed, monitored or managed. This meant people were at risk. The care records for one person included information from a healthcare professional in May 2019 about the consistency of food and fluid the person must be offered to reduce the risk of choking. The person's care plan and risk assessment had not been updated with this information. Parts of the care plan referred to giving the person food which was not safe for them. We witnessed the person being offered food which was specifically mentioned as a risk. The staff only changed this when members of the inspection team requested they did so. Therefore, this person had been placed at risk of choking or aspiration.

● The care plan for one person referred to the use of bedrails, although the person slept on a crash mat on the floor and did not use bedrails. The habit of sleeping on the floor had not been recorded in their plan or risk assessment. Furthermore, their care plan stated they were at risk of developing pressure sores and slept on a pressure relieving mattress. This was not the case as they were sleeping on a mat on the floor. This meant the staff had not accurately assessed the risks for this person or planned ways to mitigate this risk.

● We observed one person who moved around the service independently in their wheelchair. The foot plates of the wheelchair were in place, but the person did not use these when mobilising themselves and their position presented a risk of injury to the person's legs or feet. We also saw staff moving this person's wheelchair by pulling the wheelchair backwards, they did not secure the person's feet on the foot plates and did not notice this, until a member of the inspection team told them. This type of movement placed the person at further risk of injury as their feet could have become caught and trapped under the foot plates. The registered manager sent us a copy of the person's risk assessment stating they did not use footplates, however this was not being followed on the day of the inspection as foot plates were in situ.

● The environment was not safe and there were hazards which the staff had failed to identify or mitigate. For example, builders had left paint, glue, other chemical substances and tools, including a saw, in an unlocked lounge on the second floor, a unit dedicated for people living with the experience of dementia. The builders were not on site and were not at the service on the day of the inspection meaning the room had been left unlocked since their last visit the previous week. Call bell cords in toilets and bathrooms were tied up so they could not be reached by someone who had fallen to the floor.

The provider's failure to fully assess, plan for or manage risks meant that people were not always being safely cared for. This was a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the registered manager told us they had updated some people's care plans and

risk assessments to make sure they reflected professional advice. They told us they had also removed the health and safety hazards within the environment.

Preventing and controlling infection

● The provider had not always taken sufficient steps to prevent or control infection. During the morning of the inspection, members of the inspection team identified one person's eye was red swollen and had a discharge. There were no signs or recorded information for the staff to make them aware of this possible infection. There was also no record to show the spread of this infection had been assessed or mitigated.

● The environment was not always clean. We found toilets, commodes and toilet risers which were dirty. These remained dirty when we inspected them later in the day. We spoke with a member of an ambulance crew who were visiting the service. They alerted us to their concerns that the wheelchair for one person was dirty. Some bedrooms had an unpleasant odour and we found some carpets were stained. We saw that the tiles in one shower room were cracked and the sealant around the tiles was blackened. There were crumbs and fruit peel on chairs and floors, including in rooms which had not been used since the previous day. We also found one member of staff wore a uniform which was stained with a foul-smelling liquid. They did not change this and wore it throughout the day whilst providing care and support to people.

The provider's failure to prevent, detect and control the spread of infection placed people at risk. This was a further breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection visit, the registered manager told us they had spoken with domestic staff and were carrying out additional infection control audits.

● Gloves and hand gel were available in corridors and bathrooms. We witnessed staff washing their hands and offering some people the opportunity to wipe their hands before meals. There was an infection control procedure and regular infection control audits.

Systems and processes to safeguard people from the risk of abuse

●The provider did not always take the necessary steps to investigate and respond when there were unexplained injuries or allegations of abuse . For example, we met one person who had a bruise on their head. We looked at the person's care records. Their daily logs recorded that the bruise had been identified six days before our inspection along with two further bruises and the person's next of kin was informed. There was no other record of this unexplained injury, no investigation into what might have happened, and the local safeguarding team had not been informed. The person's care plan and risk assessments had not been updated since this occurred. The heads of each unit had a daily meeting to discuss the service, these included speaking about wounds or injuries. The meeting for the day of the injury and the following days made no mention of the bruise, although it was still evident on the day of our visit. This meant that there was no record of an investigation into what had happened had taken place and therefore potential abuse, neglect or an accident had gone unnoticed and no action had been taken to prevent reoccurrence or to ensure the person was safe.

● During the inspection visit a person made an allegation to a member of the inspection team. We asked the registered manager to investigate this further. Their response stated the person acknowledged their injury had been an accident and did not want to take this further. However, the report did not include evidence that they had addressed this with the staff concerned. We discussed this with the local authority quality monitoring team, who carried out their own investigation. They found that the person had a historic injury which required the staff to support them in a specific way. This had not happened resulting in pain for the person.

The provider had failed to effectively operate systems to prevent abuse, or investigate potential abuse. This was a breach of Regulation 13 (safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had procedures for safeguarding and whistle blowing. The staff had training in these areas.
● People using the service and their relatives told us they felt it was a safe place to live.

Learning lessons when things go wrong;
● The provider did not always do enough when things went wrong. The report of an accident on 18 June 2019 stated that a person had fallen from their bed. The report of the accident was attached to care plans identifying the risk of falls and use of bedrails written the previous day. There were no updated care plans or risk assessments to show how the risk of further falls should be mitigated. There was also no investigation into how the person could have fallen from their bed. Their care plan stated that to avoid the risk of falls, ''supervision should be provided at all times.'' The person was not allocated an individual carer and therefore was not supervised at all times. There was no other recorded protection plan for mitigating risk of further falls.
● The registered manager showed us a spreadsheet where they recorded accidents and their analysis of these. However, the learning from these was not always shared with other staff. There were records of meetings between the registered manager and small groups of senior staff where they reflected on and discussed specific concerns. This was good practice, but some of the actions from these meetings were not followed through. For example, in April 2019, the registered manager and three senior staff discussed the issue of dignity. There was a specific action that ''we will continue to address [dignity issues] at flash meetings and staff meetings.'' We looked at the staff meeting minutes for April, May, June and July. There was no discussion around dignity issues. Neither was this discussed at daily 'flash meetings'. An action set in March and July 2019 following a management meeting was to provide diabetes training and awareness to staff. There were no records to indicate this had happened. These areas were not discussed during staff supervisions, flash meetings or team meetings.

The provider's failure to effectively operate systems to monitor and improve the quality of the service or to assess and mitigate risks was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following receipt of the draft inspection report, the registered manager told us, ''The issue of dignity and good care is discussed at each meeting. It is not the company's expectation that full minutes will be made of these meetings.'' They also told us, ''In our staff meetings we discuss issues and concerns raised and we work as a team to resolve these issues, our reflective practice meeting are specific to incident and accidents''

Using medicines safely
● Medicines support was delivered by staff who were trained and competent. However, we found people did not always receive their medicines as prescribed.
● Medicines were stored securely. However, the provider could not assure that medicines were being stored under the manufacturers recommended conditions as staff were not able to accurately interpret the readings on thermometers.

The provider's failure to ensure the safe and proper management of medicines was a further breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider carried out regular audits on the management of medicines and showed some improvements had been made as a result.
● Protocols relating to the administering of when required medicines were in place and most of the protocols described the person's specific needs.

Staffing and recruitment
● People using the service and their relatives told us they felt there were enough staff. The provider had previously had staffing shortages and as a result had used a high proportion of temporary staff from an agency. Both visitors and the registered manager told us this reliance on temporary staff had reduced and there were now more permanent staff. Feedback about this change was positive. People using the service told us that call bells were answered promptly.
● The provider had systems for recruiting staff which included checks on their suitability and experience. Records of these checks were in place. New staff undertook an induction into the service and were assessed as part of this to make sure they had the skills the provider required.

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.

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

● Whilst people's nutritional and hydration needs were assessed, plans did not always accurately reflect their needs. For example, one person's care plan stated they had several medical conditions which meant they needed a specific nutritional intake. There was no reference to this in their nutritional care plan which put them at risk because there was insufficient information for staff to safely meet their needs.

● The staff told us that they only recorded nutritional and fluid intake where there was an identified risk relating to these. However, we looked at the care plans for two people where risks were identified, such as swallowing difficulties, and the food people had been offered and eaten had not been recorded. Therefore, the provider did not have effective systems to monitor whether people had been offered appropriate food to meet their needs. We found one person being offered a type of food which presented a risk. Because there were no records of previous food intake for this person, the provider was not able to assure us that this had not happened before.

● The catering staff did not have records to show details about people's individual dietary needs. They told us that this information was shared verbally from the care staff. They did not have formal systems for meeting with people using the service or discussing their preferences or needs.

The provider had not always planned for or monitored that people's nutritional needs were being met. This was a breach of regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Feedback about the food from people who used the service was varied. There was a set menu which offered a choice at each meal. We saw that people were offered regular fluids throughout the day and cold drinks were available in bedrooms and lounges.

Staff support: induction, training, skills and experience

● The staff did not always receive the supervision, support and information needed to provide effective care, although this had improved. We found that the staff had not understood some training they had been given and were not able to describe certain procedures or how to provide good dementia care. Our observations were that the staff did not always understand about dignity or treating people in a respectful way. We discussed this with the registered manager who informed us that they would be providing additional training and support for the staff in this area.

● There was evidence that the majority of staff had participated in individual meetings with their line manager. However, records of these did not indicate personalised discussions about the staff member's

performance and development needs, as records showed the same discussions with all staff about only some areas of their work. Records of supervision meetings sometimes included negative feedback from staff, for example we saw two members of staff had requested more training and one of these staff had stated they wanted more management support. There was no record to show what had been done as a result of this feedback or to support these staff.

● There were regular team meetings, but these did not always include discussions about relevant issues. For example, management meetings which had been recorded as 'reflective practice', included actions where specific topics such as falls, dementia and dignity would be discussed with the staff team. There was no record to show these issues had been discussed, and our observations were that staff lacked some awareness of these issues.

● The registered manager told us that they had enrolled the majority of staff on training the provider considered mandatory and we saw evidence of this. Feedback from one visitor showed that they felt staff knowledge and training had improved. They said, ''Staff appear to be better trained now.''

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

● People's healthcare needs were recorded in care plans. There was evidence they had access to different healthcare professionals. The GP visited the home each week. The staff had made referrals to other healthcare professionals when there was an identified need. However, we found that their advice and guidance had not always been included in care plans, so people were not always receiving the care recommended by these professionals. For example, information regarding diabetes, aspiration risks, advice from the GP to monitor people's wellbeing and changes to their mobility needs had not been included in plans or evaluations and this information could only be accessed by reading recorded made by the healthcare professional themselves.

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

● The provider had started to make improvements to the environment. These included making feature murals on the second floor and creating a coffee lounge on the ground floor. However, the environment was not designed in line with best practice guidance around dementia friendly environments. Some bedroom doors were identified by only a number. Where names were displayed on some rooms, these were often accompanied by pictures which were not relevant to the person, such as cartoon characters. We looked at a sample of care plans to see if people had expressed an interest in these particular characters, but there was no record of this. Notice boards were not always informative, with information for staff and people using the service on the same boards, information covered up, posters which had been scribbled or written on and some boards displaying the wrong date or information.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● The provider had assessed people's needs before they moved to the service and during admission. These assessments included asking people for their views and preferences as well as talking to their representatives and professionals who supported them.

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 was acting in accordance with the MCA. They had assessed people's mental capacity and these assessments were recorded. Where people lacked the mental capacity to make decisions about their care, the provider had applied for DoLS authorisations. We saw evidence of these and where conditions were in place, the provider had met these conditions.
- There was evidence that the provider had liaised with people's representatives to make decisions in their best interests. These were recorded and reflected in care plans.

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.

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

- We witnessed a number of interactions which did not show people respect. These included one member of staff talking about people in a disrespectful way and another member of staff using swear words to describe bodily functions. There were also several incidents where the staff ignored people who spoke with them, including one incident where a person was calling out for help and another where a person was speaking with a member of staff who was pushing their wheelchair. Other staff witnessed some of these incidents and carried on without challenging the staff or appearing concerned. We discussed some of these incidents with the registered manager, so they could address them with individual staff.
- The staff tended to focus on the tasks they were performing rather than the person they were caring for. We saw people becoming distressed or confused and the staff did not respond to this or offer reassurance. When staff supported people with a task they did not always speak with them or explain what they were doing. They also left people or spoke with other staff without explaining what was happening to the person they were supporting. The staff did not always notice when people may need assistance, for example we saw one person's glasses had fallen to the end of their nose and were in the wrong position. Several staff walked past this person without noticing or acting on this.

The provider had not ensured that people were always treated with dignity and respect and this 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 and their visitors told us they were happy with the care provided and that they thought the staff were caring. We witnessed some kind interactions, where the staff were gentle and approached people in a calm and positive way. People were not rushed over meals and were able to move around the home freely if they wanted.
- The registered manager told us that since the last inspection all of the staff had attended training regarding LGBT+ (Lesbian Gay Bisexual and Transgender) awareness. Although, there were no specific practices which demonstrated an LGBT+ inclusive environment. The registered manager told us that people from a number of different religions and faiths lives at the service. We saw that there were regular church services for different dominations and communion for Catholics.
- Following the inspection visit, the registered manager told us they were planning to provide coaching sessions for staff and monthly audits of dining experience. They were also planning to provide further training and support for staff to understand dignity issues.

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

● People's views had been recorded in their care plans, where they were able to voice these. There was an emphasis in the care plans that people should be offered choices about their care. Records of daily care given indicated that people had made some choices, such as what they wore and where they spent their time. However, the staff did not always offer people choices, choices that were offered were not always meaningful. For example, we heard staff showing people with dementia written menus and asking, ''do you want option one or two?'' but not explaining what the options were or talking about these.

● The provider operated a 'resident of the day' system. However, this was used solely for the staff to review and evaluate care plans each month. People using the service were not invited to participate or asked about their views of the service and any changes they wanted. Relatives were not involved in this either, although the registered manager told us that some relatives visited often and were involved in giving feedback and making decisions about people's care.

Respecting and promoting people's privacy, dignity and independence

● We witnessed one incident where a member of staff entered a person's room (which the person was in) without knocking or speaking with the person once they entered. However, we also saw other staff knocking on bedroom doors. The staff pulled doors closed and used signage to indicate when people were being supported with personal care or should not be disturbed.

● People told us they had been asked about whether they wanted same gender carers and we saw their decisions had been recorded.

● People were supported to maintain their independence to some extent. One person told us that they had been enabled to make their own hot drinks and we saw that care plans recorded when people were able to do something for themselves. People were able to eat and drink independently, and the staff did not try to rush them or interfere with this. However, there was limited therapeutic input into the daily activities, and people were not always engaged or enabled to try new skills or be involved in individual activities.

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 our last inspection the provider had not always ensured people's needs were met in a personalised way. Plans about people's care needs did not always include information about how needs should be met. At this inspection, we found that there had been some improvements to care planning, but these were not enough. In addition, we identified new concerns about the way in which people were cared for and supported. This was a breach of Regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's needs were not always planned for or recorded so that care could be provided to meet these needs. We observed that one person spent their time on a mat on their bedroom floor. The staff confirmed this was regularly the case, as did the notes of their care during the day and night. The staff also described a behaviour associated with their elimination. This was not recorded in the person's care plan and there was no plan to support the person with this need.
● Care plans were not always accurate. For example, one person was identified as requiring thickened fluids and specific consistency food. However, their oral care plan referred to the person being offered clear fluids, with no reference to these being thickened. Care plans were not always personalised. The care plans for people referred to generic guidance and some without any reference to the person's individual needs or preferences.
● Where specific needs were identified there was not always the evidence that these needs were being monitored or met. For example, one person's care plan stated that their feet should be washed, dried and checked daily because this was an area of specific need. There were no records to show this had happened. Where people had identified oral care needs there were no records to demonstrate these needs had been met. This was particularly evident for a person who was 'nil by mouth.' Their care plan stated they required regular oral care to avoid infections. There were no records to show that this care had been completed.

The provider's failure to ensure that people received care which was personalised and met their needs was a repeated 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 take part in a range of appropriate activities. Whilst the provider employed activity coordinators, these staff were not skilled or knowledgeable about appropriate activity provision or

dementia. People's individual needs and interests were not being met through the planned programme of activities.

● During the morning of our inspection, we witnessed people being left with nothing to do. Some staff tried to encourage people to participate in colouring, jigsaw puzzles or games. However, they did not give people choices, explain what was happening and largely did this activity themselves next to people without communicating with them. People were given free newspapers to look at, but these were a business paper, and although some people may have been interested in this, this newspaper was not appropriate for the majority of people. People were not given a choice of television stations, which were left on throughout the day. We observed an activity involving a balloon, but staff did not explain what was happening or ensure people were happy and felt safe.

● Furthermore, the staff did not have sustained engagement with people. Apart from at mealtimes, one member of staff tended to be in communal areas with people. These staff regularly changed over, and there was little or no communication with people when they entered and left the room. Whilst spending time with people, the majority of staff sat next to people but did not engage with them. Records of care provided to people showed very little variety in their daily lives. People who spent the majority, or all, of their time in bedrooms told us that they did not receive social visits from the staff and were not given things to do, although they enjoyed visits from relatives. One person told us they were ''lonely.''

Failing to provide care and support which reflected people's individual needs was a further breach of Regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager explained that they had plans to improve activity provision. They told us the activities coordinators were going to attend training and learn more about their role. They also said that they were planning specific projects, such as caring for chickens and getting a therapy dog for the service. There had been some special events, the registered manager told us there had been an Easter Egg hunt and an entertainer who regularly visited to play music.

● Visitors were welcome at any time, and there were regular visitors who told us they spent much of their time at the service. They said they were informed when people were ill or following an accident. They told us there were no restrictions on their visits. The registered manager told us that children related to people who lived at the service and staff visited, but there were not any connections with local schools or nurseries.

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.

● Care plans included basic information about hearing or sight impairment and whether people needed additional aids in relation to these. Some people did not speak English as a first language. One person was able to communicate with a member of the inspection team in a different language. They said that the staff did not attempt sustained communication with them and did not use any resources to help translate. A representative of the local authority confirmed this was the case for another person who spoke a different language. They said that they had used a translation application to communicate with this person but that this did not happen at the service.

● Some people living at the service had learning disabilities. The registered manager told us that communication with these people was limited. However, there were no systems to support positive communication using objects of reference, sensory communication or other resources.

The provider's failure to ensure that the AIS were implemented at the service was a further breach of Regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

● There was a complaints procedure and people were made aware of this. People using the service and relatives told us they knew who to speak with if they had concerns. They also told us that resolution of concerns had improved since the registered manager had started work at the service. One person told us, ''The manager is willing to listen, and she tries to resolve issues quickly.''

● The registered manager kept a record of formal complaints and the investigation into these. This showed that complaints had been responded to.

End of life care and support

● Some people were being cared for at the end of their lives. There were appropriate care plans in place regarding pain management and comfort. The staff worked with palliative care teams to monitor people's needs. The staff had also recorded 'end of life' care plans for all the people living at the service. These outlined specific wishes or requirements for care at the end of their lives, should they need this, and funeral arrangements.

Inadequate

Is the service well-led?

Our findings

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

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

Continuous learning and improving care

At our last inspection the provider had not always ensured that systems and processes were effectively operated to monitor and improve the quality of the service. At this inspection we found this was still the case. This was a breach of Regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The service has failed to meet regulations relating to person-centred care and good governance at all four of the inspections since the service was registered under the current provider. Whilst improvements were noted at the previous inspection, there has been a deterioration in some areas since then. Therefore, the provider has failed to sustain the improvements they had made.
- People were not always safe because the provider had failed to assess, monitor and mitigate risks to their health and wellbeing. This included risks within the environment and the practices of staff, as well as inaccurate records which did not fully take account of people's needs and the risks relating to these. Furthermore, they had not always responded to accidents and incidents to make sure these were fully investigated and learnt from.
- People were not always treated with dignity or respect and did not receive personalised care which met their needs. The staff did not have a good understanding about these areas and provided care which was task based, following care plans that did not give specific information about their needs.
- We were alerted to concerns about the service from the local authority, who undertook monitoring visits. They had identified concerns about safety, lack of dementia friendly environments and activities and inconsistent records. The local authority is continuing to monitor the service. Our findings corroborate some of their concerns.
- The registered manager told us they had made improvements to the way the service was monitored. They had a spreadsheet which they updated monthly which included information about accidents, incidents, falls, safeguarding alerts, pressure ulcers, changes in people's weight and hospital admissions. This was shared with the provider and included analysis of adverse events. The registered manager told us the support from the provider had improved in recent months.

The provider's failure to ensure they effectively operated systems and processes to improve quality and to monitor and mitigate risk were a repeated breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● People using the service, their visitors and the staff gave us positive feedback about their experiences. Whilst some people had individual concerns, most fed back that they were happy. However, our findings were that care was not always person-centred and people were not always empowered or included in making decisions about their lives.

● There had been improvements in staffing levels and retention at the service which had a positive impact. The service relied less on agency (temporary) staff and the registered manager told us that staff enjoyed working there and there were low sickness levels.

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 record of complaints indicated that the registered manager had spoken with complainants about their concerns and apologised when things went wrong. Visitors also confirmed this.

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

● The registered manager was a qualified nurse and had previous experience in managerial roles. They were supported by a clinical lead and deputy manager at the service. They had made some improvements to the service and understood the need for these. However, there were repeated breaches of Regulations and deterioration in some standards since the previous inspection. The staff did not demonstrate an understanding of some key areas, such as providing personalised individual care and people were not always safe.

● People using the service, visitors and staff were positive about the registered manager. They said they were approachable and listened to them. They felt the registered manager had introduced some positive changes to the service.

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

● The provider invited people using the service and their representatives to attend, 'resident and relative meetings.' These included sharing information about the service and asking for any feedback or ideas.

Working in partnership with others

● The local authority organised provider forums which the registered manager attended and met with other providers to share ideas. The local authority also carried out quality assurance visits. The registered manager told us they worked closely with this quality assurance team to discuss ways to improve 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 ensure that the care and treatment of service users was appropriate, met their needs and reflected their preferences. Regulation 9

The enforcement action we took:

We have imposed conditions on the registration of the service.

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 persons did not ensure that service users were treated with dignity and respect. Regulation 10

The enforcement action we took:

We have imposed conditions on the registration of the service.

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 ensure that care and treatment were provided in a safe way for service users. Regulation 12

The enforcement action we took:

We have imposed conditions on the registration of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and

Treatment of disease, disorder or injury	improper treatment The registered person did not always ensure that service users were protected from abuse and improper treatment. Regulation 13

The enforcement action we took:

We have imposed conditions on the registration of the service.

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 and processes to monitor and improve the quality of the service, or to assess, monitor and mitigate risks to the health and wellbeing of service users. Regulation 17

The enforcement action we took:

We have imposed conditions on the registration of the service.