Beaconsfield Care Limited

Mayfield House Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 13 and 19 December 2018 and was unannounced. Our last inspection was in June 2018 where we rated the service 'Inadequate' and placed it in 'special measures'. We identified five breaches of the legal requirements in relation to consent, risk management, infection control, medicines, person-centred care, dignity and governance. This inspection found continued concerns in these areas and three additional breaches of the legal requirements in relation to recruitment checks, maintenance and notifications to CQC.

Following the last inspection, we met with the provider and asked the provider to complete an action plan to show what they would do and by when to improve all five key questions to at least good. There had been ongoing meetings with the local authority and the provider submitted weekly action plans to CQC. Our findings at this inspection showed that whilst action had been taken to address individual issues, there were continued breaches of the legal requirements of the regulations.

Mayfield House 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.

Mayfield House accommodates up to 34 people in one adapted building. The service supports older people who have physical conditions and require support with mobility. The majority of people at the home were living with dementia. At the time of our visit, there were 19 people living at the service.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were not always protected from avoidable harm because known risks had not always been assessed and the plans to reduce risk were not always implemented robustly. The home environment lacked cleanliness and people's rooms and equipment were not always in a safe condition. We had urgent concerns with some maintenance issues with the home environment and asked the provider to take immediate action to keep people safe, these urgent concerns had been addressed by the second day of our inspection.

People's medicines were managed safely but there was a lack of information about 'as required' medicines in people's records. People's healthcare needs had not always been met. We found continued shortfalls in how people's healthcare appointments were tracked and found instances where changes to people's health had not been responded to robustly.

People's legal rights were not protected because staff did not always follow the process outlined in the

Mental Capacity Act 2005 (MCA). Restrictions had been placed on people without consent and the registered manager lacked understanding of how to apply the MCA. Best practice had not always been followed for people living with dementia and the home environment was not always suited to people's needs. Staff lacked knowledge and understanding and systems to track training were not in place. We received negative feedback about the food and staff did not always have the right training to meet people's nutritional needs.

People did not always receive dignified care because they lived in an unclean and malodourous environment. We identified instances where people's personal hygiene needs had not been met which impacted on their dignity. People told us that staff regularly entered their rooms without knocking and there was a lack of involvement of people in their care.

There was a continued lack of opportunities for people to go out in the community and people told us they felt bored by the activities on offer. Care plans were not personalised and were written in identical ways, we found instances where important information about people's needs were missing. There was a lack of information about people's wishes regarding end of life care. There was a complaints policy in place but people did not feel their complaints would be addressed if they raised them.

We received mixed feedback about the management at the service. The provider's own checks and audits had not identified and addressed the concerns we found and the action plan drawn up following our last inspection had not been effective. We found instances where records were not up to date and did not reflect care delivery.

Staff understood their roles in safeguarding people from abuse and there was a record of incidents which was monitored by management. There were enough staff deployed to meet people's needs but there was information missing from recruitment checks for new staff. We observed some pleasant interactions and there was information in care plans about how to encourage people to maintain skills and independence. Staff felt supported by management and we saw some evidence of work with stakeholders and the community.

The overall rating for this service is 'Inadequate' and the service remains 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 take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

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 take action 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?

Inadequate

The service was not safe.

Risks to people were not routinely assessed and we found instances where plans were not being implemented properly. There was a lack of cleanliness which exposed people to the risk of infection.

People's medicines were administered safely but we found a lack of information in records relating to 'as required' medicines.

The home environment was not safe and we identified a number of maintenance issues that posed risks to people.

Some staff had not been through robust recruitment checks. We made a recommendation about recruitment checks

There were enough staff to meet people's needs. Staff understood their roles in safeguarding people from abuse.

Is the service effective?

Inadequate

The service was not effective.

There was a lack of understanding of the legal processes for obtaining consent and restrictions had been placed on people without the correct process being followed. This was the fifth inspection that found shortfalls in this area.

People's healthcare needs were not met because the provider did not always respond promptly to changes in people's health and there was not a robust system to track appointments.

We received negative feedback on the food and there was a lack of planning for people's nutritional needs.

Staff did not always have the right training and support for their roles.

Systems were in place to ensure people' needs could be assessed before coming to live at the service.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us staff did not always respect their privacy.

People's dignity was not promoted as we found personal care needs not met and people lived in an unclean home environment.

There was a lack of evidence in people being involved in their care.

We saw examples of people being supported to maintain their independence.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There had been some improvements to activities but there was a lack of opportunity to go on outings and people gave negative feedback on the available activities.

Care was not always planned in a personalised way and information about people's needs and preferences was inconsistent.

There was a lack of evidence that information about end of life care had been sought.

Complaints had been documented and addressed, however people did not feel confident any issues they raised would be addressed.

Is the service well-led?

Inadequate

The service was not well-led.

There had been a failure to implement improvements at the service to ensure the legal requirements of the regulations were met.

The provider's checks and audits were not sufficient to identify and address the serious concerns we found during this

inspection.

Records were not always up to date and accurate.

There was a failure to submit statutory notifications to CQC when required.

Staff felt supported by management and work was underway to improve links with the community and stakeholders.

Mayfield House Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check 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.

The inspection took place on 13 and 19 December 2018 and was unannounced. The inspection was carried out by three inspectors.

As part of our planning we contacted the local authority and placing authorities for feedback on the service. We reviewed information shared with CQC by the local authorities monitoring of the service through ongoing provider failure meetings. We reviewed feedback from people and relatives submitted to CQC and we also checked online feedback.

We reviewed statutory notifications that the provider had submitted to CQC to identify any areas that we would need to follow up on during our visit. Statutory notifications are notifications of important events that providers are required by law to submit to CQC.

As part of the inspection, we spoke with four people and two relatives. We observed people and staff interacting and taking part in activities and a meal. We spoke with the registered manager, the administrator, a kitchen assistant and three care staff. We looked at care plans for four people, records of incidents, complaints and records of checks and audits. We looked at two staff files and records of staff meetings and residents meetings.

Inadequate

Is the service safe?

Our findings

At our inspection in June 2018, we identified that risks to people were not being safely monitored and there was a lack of planning to reduce risks. We also found shortfalls with the way people's medicines were managed and a lack of cleanliness and safety of the home environment. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In response, the provider submitted an action plan to CQC stating that these issues would be addressed by the end of August 2018. We saw the provider had implemented changes to records and repairs to the home environment had been carried out in response to the specific issues described in our last report. However, this inspection found continued shortfalls in these areas.

Risks to people were not always safely managed. Whilst we did note some improvement to the quality and format of risk assessments and plans, these had not yet fully addressed our concerns in this area. We identified instances where known risks had no plans in place to reduce them. One person's records stated that they had swallowing difficulties. This meant there was a risk of them choking or suffering aspiration, which could lead to chest infections or pneumonia. Despite the registered manager telling us they were aware of this risk, there was no risk assessment or plan to describe how to support this person to eat safely. We identified two people who required hourly checks at night, to reduce the risk of falls. Records showed that these were not taking place every hour as planned and they were documented amongst their daily notes. This made night checks difficult to monitor and showed risks were not being managed in line with risk plans because these checks were not taking place every hour.

Another person had a risk plan for falls which said they were meant to be supervised when mobilising. Despite this plan being in place, we observed the person moving independently in the lounge without staff supervising them. In another instance, a person's care plan documented they could become aggressive. The registered manager described how staff approached this person and one member of staff was knowledgeable about how to support the person safely. However, there was no recorded plan to provide guidance for staff on how to reduce this risk. This showed that whilst the level of detail in risk plans had improved, plans did not cover all risks people were exposed to.

People were not always protected against the risk of the spread of infection. People's rooms were not always clean and furniture and equipment had deteriorated in a way that meant it could not be cleaned properly. In people's rooms and communal areas we found cushions and chairs with frayed or broken covers, as well as furniture which had broken leaving unvarnished surfaces exposed. These issues heightened the risk of the spread of infection as fluids and bacteria would be able to permeate the exposed fabric or wood. This would allow infection to spread because these surfaces could not be properly cleaned.

There was a lack of cleanliness in people's rooms. Despite our inspection in June 2018 identifying infection control risks due to shortfalls in maintenance, this inspection found further concerns in this area. One person said, "It could be cleaner. It's not as clean as it could be. I have never seen them clean the doors with a damp cloth." We checked this person's door and as they had pointed out it was grubby and did not appear to have been recently cleaned. We also found surfaces and walls which were not clean and three people's

rooms smelt of urine. In one room a person's bed and cushions smelt strongly of urine and in another the odour was coming from the floor. Another person's bathroom contained a shower caddy that had been left to rust which was also dirty and had not been cleaned. The provider told us they checked the cleanliness of the home daily but their checks and audits had not picked up these issues.

People's medicines were not always managed safely. Where people received medicines on an 'as required' basis, there was a lack of protocols in place to guide staff when these medicines may be required. For example, one person was living with dementia and would not always be able to verbalise that they were pain. There was no protocol in place to guide staff for additional signs, such as changes to behaviour or presentation, that could indicate that the person was in pain. People's medicines were stored securely with checks to ensure they were stored at the correct temperature. Staff had completed medicine administration records (MARs) and the records we checked were completed accurately, with no gaps. Staff had been trained in how to administer medicines and demonstrated a good understanding of how to do this safely.

The lack of robust response to risk, lack of cleanliness and the shortfalls in medicines records were a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home environment was not safe. People's rooms contained multiple maintenance issues which impacted on the safety of their living environments. In one person's room we found a long television aerial cable hanging from the wall which could present a risk to them as a ligature and potential electrical risk. Another room had a window which was propped open by a plastic cup, when the cup was removed the window slammed closed with force which presented a risk of injury if a person's hand was there. Another person's room had a table that was in use but had split with protruding sharp edges, which increased the risk of cuts or splinters to the person.

After the first day of the inspection, we issued an urgent letter to request these safety concerns were addressed immediately. The provider responded within the timeframe we gave and submitted evidence to show these safety risks had been addressed. On our second visit we found these urgent risks had been managed through maintenance works, cleaning and replacement of furniture. However, we will require further action to ensure the home environment and people's equipment is maintained proactively.

The shortfalls in the maintenance of people's home environment was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected from being supported by inappropriate staff because robust recruitment checks were not always carried out. We checked two staff files for evidence of recruitment checks and found some checks were missing. Both staff had been recruited since our last inspection. In one file, there was an inconsistency in the dates in the staff member's work history and references which the provider had not clarified. There was also no evidence of a check with the Disclosure and Barring Service (DBS), but the registered manager said they had a picture of the certificate. On the second day of our inspection, a copy of the DBS certificate has been put on file and the dates had been clarified. However, both files checked did not have evidence of a health declaration, to show staff were fit and able to provide care to people. This showed that the systems to check new staff was not robust and staff files were not kept up to date.

The failure to maintain accurate records relating to recruitment checks was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since our last inspection, the provider had introduced a system for documenting accidents and incidents.

These allowed incidents to be monitored and the accuracy of these records had improved since our inspection in June 2018. We saw evidence of additional measures to reduce risk being introduced following falls, such as one person who had a sensor mat installed after they fell. However, we did note that reviews of risk assessments were not always carried out promptly and we identified an incident related to a person's health needs which was not followed up robustly which we have reported on in the Effective domain.

There were sufficient numbers of staff to meet people's needs. Whilst we identified a number of issues with care practice which was impacting negatively upon people, we observed staff were able to support people safely. At the time of this inspection, there was a voluntary embargo in place which meant there were fewer people living at the service than had been previously. A voluntary embargo is a commitment made by the provider in writing to CQC and the local authority that they would not accept any new admissions. The provider told us they had sustained the previous staffing levels in order to implement improvements at the service, and records confirmed this.

Staff understood how to escalate safeguarding concerns. There was a safeguarding policy in place and staff had received training in safeguarding adults. Staff were aware of how to identify potential abuse and were able to describe how they would escalate concerns if they felt abuse had occurred.

Inadequate

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When 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 application procedures called the Deprivation of Liberty Safeguards (DoLS).

At our inspections in August 2015, August 2016, June 2017 and June 2018 people's legal rights were not protected because staff were not following the correct process as outlined in the MCA. People's mental capacity to make decisions had not always been assessed and where restrictions were placed upon people, they had not always consented to them or the necessary approval had not been sought from the local authority DoLS team. This was a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we checked whether the principals of the MCA were being met and found continued shortfalls in this area.

People's legal rights remained unprotected because staff did not follow the legal requirements of the MCA. One person said, "I think staff only cater for very old people, I feel patronised. They treat me as though I don't have capacity." The registered manager told us that as part of their action plan they had reviewed people living at the home to check the accuracy of records relating to people's capacity and DoLS applications. Despite this, we found inconsistencies in this area. For example, one person had a mental capacity assessment carried out in September 2018 which said that they had the mental capacity to make a decision to go out unaccompanied. Even though the person was assessed as able to make this decision, an application to restrict their liberty was lodged with the local authority DoLS team. This application pre-dated the capacity assessment so we asked the registered manager why it had not been withdrawn. They told us that the person required the restrictions for their safety and they could not go out alone due to their needs, rather than a lack of capacity. This showed a misunderstanding of the legal process because where people have capacity, restrictions cannot be placed on them without consent. After the inspection, we made a referral to the local authority safeguarding team who established this person lacked capacity and did require restrictions in place.

Another person had limits placed on their alcohol intake to keep them safe, despite having the mental capacity to make this decision themselves. The person's relative described how this restriction had a positive impact on the person and their relationship. However, there was no signed consent from the person for this restriction and the person said they were not always happy with having these restrictions placed upon them. We identified this same issue for the same person at our inspection in June 2018 and actions taken since had not ensured the person had consented to this restriction. We also found mental capacity assessments were not carried out for every decision that had been made on people's behalf. For example,

people had been taken for flu vaccinations without evidence of capacity assessments having been carried out, or staff requesting healthcare professionals check capacity before carrying out procedures. One person's daily notes recorded that a person had 'consented verbally' to a vaccination despite the provider's records showing the person lacked capacity to make other decisions about their care. There was no evidence of staff advocating for the person to request an assessment to ensure their legal rights were protected.

The lack of understanding of the MCA and failure to follow the correct legal process was a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection in June 2018, people were not always being supported to access healthcare professionals when required. Records relating to people's healthcare appointments were inconsistent and we found examples where people had not seen healthcare professionals for appointments and check-ups when required. At this inspection, we found continued shortfalls in this area.

People's healthcare needs were not always met. Whilst we found new trackers had been introduced for people's healthcare appointments, these were not always accurate which meant it was difficult to track people's healthcare appointments. For example, three people's trackers showed no recent check-ups with dentists or opticians so staff could not ensure these check-ups were being attended on time. An incident record showed one person had a fall in November 2018 and a recorded action was 'GP contacted for home visit'. Despite the registered manager telling us this appointment took place, there was no record of the GP visit and no record of what the outcome was.

We also found instances where changes to people's health were not being responded to promptly. One person's records showed they had lost consciousness suddenly in October 2018 and had a potential stroke or seizure. We saw records to show the GP had been called and paramedics attended the person. The person was not admitted to hospital as they had regained consciousness and there was no longer an acute need for urgent care. Despite this episode clearly showing a potential change to the person's health, they had not seen the GP since it happened. The registered manager said information had been faxed to the GP, but they had not felt the person should have a health check-up even though it was not clear what had happened when this person lost consciousness. No information had been added to the person's care plan to provide guidance for staff on what to look for in the event of a similar episode happening again. This response was not robust enough to ensure any future changes to the person's health could be responded to appropriately by staff.

Best practice was not always followed for people living with dementia. Whilst we did see there was signage around the home to help people to orientate themselves, this was not always accurate. For example, one person's room had two different numbers on it which could be confusing as the person was living with dementia. As described in the Safe domain, we also found shortfalls in the home environment that meant it was not always safe and could place people living with dementia at risk of harm. There was a planner on the wall on the day of our inspection which recorded the date and time and activities. This documented that hairdressing was due to take place but when we asked we were told a chiropodist was coming in. This meant information provided to people living with dementia to orientate themselves around the home was not clear and could cause confusion.

We received mixed feedback about the food. One person said, "The food is good." However, another person told us, "Out of ten I would go half way. It's never hot enough for me." Another person said, "It's a bit repetitive but adequate." There were not always foods to cater for all dietary needs. We saw there was a menu in place which provided a choice, and people who needed soft foods had options on the menu.

However, for snacks between meals there was only biscuits available. The kitchen staff told us there was no option for people who were not able to eat biscuits. We raised this with the administrator and registered manager who said people had not requested anything, but our findings showed there was no option put to people who required soft foods.

The shortfalls in responding to people's healthcare needs and the lack of good practice in dementia care and dietary needs were a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not always have the training and support for their roles. Staff told us that they received training and we saw evidence of courses having been attended. However, we identified instances in which staff training was lacking because staff lacked knowledge of people's needs. Kitchen staff were not aware of planned changes to food textures which were being implemented nationally in 2019. They also told us that they had never received training in food textures, despite preparing meals for people who were at risk of choking or dysphagia. We informed the registered manager of this and they printed off a fact sheet from a large commercial frozen food provider, but this did not constitute training or best practice guidance. Staff said they had received training in dementia care but we observed practice that showed improvements to staff skills were required. During an activity, a staff member did not show patience when supporting people living with dementia to take part in a quiz. They did not allow time and rushed people, moving on before they had a chance to contribute. This showed a lack of understanding of how to provide considerate and dignified care to those living with dementia.

Staff told us that they received regular one to one supervision meetings. However, our findings showed that ongoing staff supervision had not identified and addressed the shortfalls in training we found. After the inspection, we were sent a copy of the provider's training matrix which showed training was being regularly completed. However, our findings showed more action as required to ensure training impacted positively on care delivery.

The shortfalls in staff training were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems were in place to ensure people received an assessment before receiving care. After our last inspection, the provider had agreed to a voluntary embargo so there had been no new admissions since our last visit. There was a new electronic care planning system in place and we saw this had a function for a detailed assessment.

Requires Improvement

Is the service caring?

Our findings

At our inspection in June 2018, we identified issues with the home environment that impacted on people's dignity. People lived in unclean rooms with unpleasant odours and there was a lack of evidence of involvement of people in their care. We also saw examples of people's privacy not being respected. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2008 Regulations 2014. At this inspection, we identified continued concerns in these areas.

People told us that they did not always feel their privacy was respected. One person said, "Some staff knock and some don't and it's not good enough. I could be walking around with no clothes on."

Two people told us that staff regularly entered their rooms without knocking. Whilst we did observe staff knocking before entering rooms, people's feedback was that this was not always the case. We also found that information about a person's medical condition had been documented in a way that did not reflect recognised best practice about confidentiality.

People's dignity was not always upheld because their care needs had not been fully met. During the inspection we noted people's personal care needs had not been fully met. We spoke with one person who had an odour coming from their mouth and records did not document whether they had received oral care on the day of our visit. We checked toothbrushes in people's rooms, including this person's, and they were dry and congealed. This showed they had not been used and people's oral care was not always being carried out. Staff were not recording when this had been done or whether it had been refused, which had led to people not always being well kempt which impacted on their dignity.

We visited people's rooms and found cleaning and maintenance shortfalls that meant they lived in a home environment that was not well looked after. One person's room had exposed and dirty pipework and the shortfalls described in the Safe domain showed a lack of attention to detail. Three people had rooms which smelt strongly of urine which had not been picked up and addressed by staff, which showed a lack of consideration of people's dignity. Despite the provider submitting an action plan which stated action had been taken to improve people's home environments, our findings show this had not had a positive impact on people's dignity.

The failure to ensure care was delivered in a way that was supportive of people's privacy and dignity was a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed instances where staff showed kindness and compassion towards people. During lunch, a staff member sat with two people and had a discussion. The conversation was lively and the staff member asked after people's welfare and discussed plans for the day. This was a warm interaction and people looked happy and comfortable chatting to the staff member. Later, we observed staff reassuring a person who had become anxious, they knelt down to the person's eye line and spoke softly to provide some reassurance to them.

Care plans documented people's strengths and personal care tasks that they were able to do themselves. One person told us staff allowed them to meet their own needs and were aware of their strengths. Evidence of people's involvement in care was limited, care plans did not always reflect people's individual needs and preferences. However, we did observe staff offering people choices with drinks and meals. When asked, staff also demonstrated an understanding of how to provide choices to people living with dementia.

Requires Improvement

Is the service responsive?

Our findings

At our inspection in June 2018, we found a lack of variety of activities for people and no opportunities for people to access the community. We also found care planning was inconsistent and there was a lack of information about people's needs and preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found some improvements in this area but the legal requirements of the regulation were not fully met.

We received negative feedback about the activities on offer. One person said, "There aren't enough activities, I get bored. I do my crosswords. I would like to get out of here." Another person said, "I'm not occupied, there isn't enough to do." A relative said, "They are all just sat down, very sedentary. There could always be more for [person] to do."

People did not always have access to varied activities. After our last inspection, the provider told us that they had increased opportunities for people to go on outings. We saw photographs of these and did see evidence of some people going on outings within daily notes. However, people still went long periods without being supported to go out. For example, one person living with dementia had a care plan that documented they were active and liked the outdoors. Daily notes showed that the person was often restless and staff described to us how they walked around the home with purpose every day. Despite the potential of outings to help this person's wellbeing, we could find no evidence of an outing in the last month for them. After the inspection, the registered manager submitted evidence of outings for people and these showed this person had not been on an outing since September 2018, nearly three months before our visit. The evidence submitted also showed that of the 19 people living at the service, only seven had been supported to go on outings within the last three months. Whilst this was an improvement on our visit in June 2018, there was still more work required to ensure people had opportunities to go out regularly.

There was a programme of in-house activities which had been updated since our inspection in June 2018. However, as reported on in Effective the scheduled activities on the day of our visit did not take place as planned. We reviewed daily notes and saw activities people took part in were being recorded. However, the activities were repetitive and people told us they did not always feel engaged and sometimes felt bored. People's feedback on the activities was negative and this had not been picked up or addressed through the provider's own systems for gathering feedback or suggestions from people. This showed people were not always involved in choosing and influencing activity choices.

Care was not always planned in a personalised way. Since our last inspection, the provider had introduced an electronic care planning system. Whilst this had caused some improvements to the level of detail within care plans, we found instances where care plans were not written in a way that was personalised to people's needs. Two people were living with dementia and had dementia care plans. Both of these care plans had identical wording which showed that they had not been drawn up individually. Both people had different backgrounds and dementia affected them in different ways but the care plans were identical. For example, both care plans stated, '[Person] often walks without apparent purpose' when one of the people's care plans also documented that they regularly spent time seated or in bed. The person's daily notes reflected

that they did not often walk around the home as their care plan said and a member of staff confirmed this to us.

There was a lack of information about end of life care. We checked care plans and these did not contain information about people's advanced wishes or their preferences for when they reached this stage of their lives. The registered manager told us everyone at the home was not willing to discuss end of life care and this had been documented. However, we saw people with 'Do Not Attempt CPR' (DNACPR) forms where this had been discussed with relatives and the GP. Some people living at the home lacked capacity to make decisions about their care and had relatives who would be able to provide input regarding end of life care planning. Despite this, there was no evidence of efforts made to discuss end of life care with relatives.

The shortfalls in activities, care planning and end of life care were a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection in June 2018, information provided to people about how to complain was not accurate which was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, the provider had made the necessary improvements to meet the requirements of this regulation.

One person told us they did not feel their complaints would be responded to or addressed. One person said, "I would complain to [registered manager] but I wouldn't feel confident they would deal with it." The provider had a record of complaints and there had only been one complaint since our last visit that had been raised through CQC. The provider had updated their complaints procedure in response to our last inspection to ensure people were aware they could contact the Local Government and Social Care Ombudsman (LGSCO). People told us they did not always feel complaints would be dealt with which showed more work was required to ensure people felt confident in the management of the service so that they would raise any issues.

Inadequate

Is the service well-led?

Our findings

At our inspection in June 2018, we found that audits had not been robust enough to proactively address issues relating to documentation and the home environment. We also found that records were incomplete and lacked accuracy, with minimal monitoring from management. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found that some action had been taken but the legal requirements of this regulation were not met.

We received mixed feedback about the management at the service. One person said, "You don't see them for one thing. I don't feel the manager has an open door." Another person said, "[Administrator] is good but to be honest [registered manager] doesn't impress me." However, a relative told us, "You never feel that you can't go and speak to them [management]."

Whilst we saw evidence that the registered manager and provider had taken action in response to our findings in June 2018, there were still continued failures with governance which meant that the legal requirements of the regulation were not fully met. An action plan was drawn up in response to the shortfalls identified in June and we received regular updates. The provider used a traffic light system of 'red' amber' and 'green' to denote actions completed. The last action plan received before this inspection stated that the breaches of regulations had been addressed with actions marked as 'green' to state they were completed. Our findings showed that the actions taken were not robust enough to ensure all the legal requirements were met. In the home environment, we identified further deterioration that constituted an additional breach of the legal requirements. The registered manager had introduced audits and we saw these covered areas such as infection control, medicines and documentation. However, these had not identified and addressed the issues we found with the home environment, care planning and DoLS applications.

A recent health and safety audit carried out by the provider did not include checks of windows and people's rooms and we identified a lack of maintenance that we asked the provider to address urgently during this inspection. There remained a lack of clarity about restrictions placed upon people and their mental capacity to consent, despite action plans following four inspections since August 2015 stating improvements would be made in this area. Regular documentation audits had not picked up one person having a DoLS application in place restricting their ability to go out, despite them being recorded as having the mental capacity to make the decision to go out unaccompanied.

There had been improvements to record keeping, however, we still identified times when recording was inconsistent and lacked accuracy. The provider had introduced an electronic care planning system which stored care plans and was used to record daily notes. The level of detail in care plans had improved, but we found instances where information relating to care planning and risk was lacking accuracy. Where we identified inconsistencies in the response to a sudden change in one person's health reported on in Effective, the registered manager told us about telephone calls with healthcare professionals that were not documented. This showed that whilst there had been some improvement to record keeping, further work was required to ensure people's records were accurate and contemporaneous.

The shortfalls in governance and failure to implement improvements was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not submitted statutory notifications to CQC when required. Providers are required by law to notify CQC of important events at the service such as DoLS outcomes, injuries and deaths. We found one person who had a DoLS application approved in August 2018 and the provider had not submitted a statutory notification form to notify CQC of this despite being legally required to do so.

The failure to notify CQC was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Staff told us that they felt supported by management. One staff member said, "[Registered manager] is great, he is the best man. He knows what to do and it's always immediate." Records showed staff had regular meetings and they told us they found these useful. We did note that the agenda of meetings was similar each month and these could have been used to identify and address some of the shortfalls in staff training and support identified at this inspection. We observed staff interacting with the registered manager and being able to access them when required and this matched their feedback to us.

We saw evidence of work with stakeholders and the local community. As part of the improvements the provider had been liaising regularly with the local authority and they had attended to carry out checks and monitor the improvements. Aside from where we identified an issue with one person's care, we saw evidence of liaison with healthcare professionals and social care teams. Implementation of outings for people had caused work to begin on linking with local community organisations, but these had yet to impact positively on people's care.