Southwark Park Nursing Homes Limited

Blenheim Care Centres

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 14 March 2018 and was unannounced.

Blenheim Care Centres is a nursing and residential care home for up to 80 people located near to Gainsborough, West Lincolnshire. The home is in two buildings, Blenheim House and Blenheim Lodge. Blenheim Lodge was closed on the day of our inspection. Blenheim house consists of 35 bedrooms and some flats.

The home caters for people of ages 18 years and older, and who have physical disabilities and/or neurological conditions. On the day of our inspection 19 people were living at the home, 10 of these people received nursing care.

An unannounced comprehensive inspection was carried out on 9 August 2016 during which we identified five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches were in relation to medicines arrangements, risk assessments, the environment, infection control and prevention, governance, staffing levels and capacity assessments. At two further inspections in September and November 2016 we found that although the registered provider had taken some actions, they had not made sufficient progress to become compliant with legal requirements and improvements had not been tested for sustainability. We completed a further comprehensive inspection on 21 February 2017 where we identified that there were still concerns related to medicines management, risk assessments, completeness of care plans, staffing levels and mental capacity assessments. The home was placed into special measures after this inspection. We inspected again on 4 September 2017 we found that the provider had failed to make the improvements needed and the overall rating for this home was Inadequate and the home remained in special measures.

At this inspection on 14 March 2018, we found that some improvements had been made. For example, the management of medicines had improved and people's medicines were now ordered, stored and administered safely and accurate records were kept. However, other areas had not improved and the overall rating for this home remained Inadequate and the home remained in special measures.

Homes 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 home, 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 home. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This home 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 home. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care homes the maximum time for being in special measures will usually be no more than 12 months. If the home 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."

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

There was a registered manager for the home. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run.

The registered manager was not able to fully identify all the concerns in the home and lacked the ability to drive improvements in all areas so that people received the standard of care that they were entitled to. While staff received the training and support they needed they were not able to identify that the care provided was not meeting the latest guidance or evidence based practice. The registered manager had failed to see that the tool used to identify staffing levels was not working correctly. The turnover of staff did not support people to receive safe consistent care. Recruitment processes ensured that staff employed were safe to work with people living at the home. However, the registered manager facilitated the handyman starting before their DBS was received by asking them to work as self-employed until disclosure and barring service checks were completed.

Staff did not ensure that they accurately assessed the risks while providing care or ensure that they recorded clear guidance on how care should be delivered. Care plans contained conflicting information and would not support staff to provide safe care.

The environment did not support people's dignity and was not maintained to an appropriate standard. Empty rooms were not maintained to a standard which would reduce the risk of infection. Plans in place to improve the quality of the environment were not effective.

The audits in place to monitor the quality and safety of care were not effective and did not result in improvements to the care that people received. Systems to ensure that care reflected the latest guidance and best practice were not successful.

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 fully identified or managed.

Infection control processes were not fully effective.

Medicines were safely managed.

People felt safe living at the home and the registered manager responded to concerns.

Is the service effective?

Inadequate

The service was not effective.

The environment did not fully support people's needs.

Staff received training and support to enable them to provide safe care. However, care was not always meeting the latest best practice guidance.

People's ability to make a decision was assessed but there was a lack of information about how decisions were made in people's best interest.

The premises were not adequately maintained to support people's wellbeing and dignity.

People were not fully supported to access healthcare and healthcare advice was not always clearly recorded in care plans.

People were offered a choice of food.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's dignity was not fully respected.

People were supported to be involved in their care.

There was a good relationship between people living at the home and staff.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans did not fully support people's wellbeing

People's end of life wishes were recorded.

People were clear on how to raise a complaint.

Is the service well-led?

Inadequate

The service was not well led.

Audits did not identify concerns and actions taken to rectify concerns were not effective.

Systems to maintain and provide care in line with best practice were not successful.

Staff felt supported by the registered manager.

Blenheim Care Centres

Detailed findings

Background to this inspection

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

This inspection took place on 14 March 2018 and was unannounced. The inspection team consisted of two inspectors and a specialist advisor. The specialist advisor was a pharmacist. An inspection manager was also part of the inspection team for a short time during the morning. The service had been rated as inadequate at the last two inspections and was in special measures. We undertook this inspection as the provider had indicated to us that they had made improvements in the care provided. We visited early in the morning as we had concerns that there were not enough staff working at night.

Before the inspection we reviewed the information we held about the home. This included any incidents the provider was required to tell us about by law and concerns that had been raised with us by the public or health professionals who visited the home. The provider completed a Provider Information Return (PIR) in July 2017. They had not been asked to update this form prior to the inspection. The PIR is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make.

During the inspection we spoke with the registered manager, the regional manager and the provider. We also spoke with the nurse on duty and two members of care staff. We spent time observing the care people received. We spoke with one person living at the home.

We looked at six care plans and other records which recorded the care people received. In addition, we examined records relating to how the home was run. These included two staff records and records relating to training and supervision of staff. We looked at the competency records for seven members of staff. We looked at the staffing tool used to calculate the numbers of staff needed to keep people safe. We also looked at the audits in place to monitor the quality of care provided and a consultant's report of the quality of the care and environment dated 4 January 2018. Following the inspection the provider sent us further information on the staffing tool, the employers liability insurance certificate, the minutes of the latest

resident's minutes and a copy of the regional manager's report from their visit on 12 March 2018.

Inadequate

Is the service safe?

Our findings

At our inspection in August 2016 we identified that the provider had not ensured that there were sufficient numbers of suitably skilled and experienced staff employed to meet people's needs. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing. At our inspection in February 2017 we found that the provider had made some improvements but they had not been able to demonstrate compliance with the legal regulations. In September 2017 we found that the improvements in staffing levels and the reduced use of agency staff had not been maintained.

Before we inspected in March 2018, we had received two separate concerns that the home was short of night staff and that some shifts did not have the correct number of staff. The person raising the concerns told us that on five occasions recently night shifts had been a member of staff short. In addition they raised concerns that there were not enough staff available to cover the night shifts without working an excessive number of shifts in a row. We started our inspection at 6:30am to check the staffing levels overnight. There was a nurse and two care workers on duty. This matched the staffing levels the registered manager had identified as needed. However, the staffing rotas for the four weeks before our inspection showed that on 13 occasions there was only one care worker identified to work the night shift.

Before the inspection the local authority had shared with us the staffing tool that the home used. We found whilst people had widely differing needs the tool indicated that all but one of them required the same number of care hours. We queried this with the regional manager and they agreed to investigate. They reported back that the computer software was not calculating correctly and they would review it. The regional manager sent us an updated version of the tool after the inspection and again we saw that it had not calculated the staffing figures correctly.

The registered manager told us that they would revert back to their previous tool and sent us the September 2017 version of the tool. This split people into high medium and low dependency needs. The staffing levels were set at one nurse and two care workers over night and one nurse and three care workers during the day. Staff told us they felt there were generally enough staff on duty to provide the care people required. A member of staff said they could not always answer call bells immediately but people did not wait more than a couple of minutes. They said when a member of staff could not attend due to sickness, cover was usually obtained.

However, we found that the number of staff employed did not support people to access activities in the community. For example, staff told us that they did not have time to take people out to buy clothes, but would go into town on their day off and buy what the person needed. This was the same situation we identified at our previous inspection in September 2017 and no action had been taken to support people. Therefore we could not be confident that the staffing levels set fully reflected people's needs. As well as the care staff kitchen staff and a maintenance person worked at the home.

At the last inspection we found that the registered manager had been unable to maintain a stable workforce with a number of staff leaving. We found that this had not improved. The two night nurses who had been

employed around the time of our last inspection had then left the home and therefore the registered manager was in the process of employing a further two night nurses. This continued inability to retain staff impacted on the continuity of care that people received. All the night nurse shifts in February 2018 had been covered by agency staff. In addition, a cleaner, handyman and care worker had also left along with the deputy manager since the last inspection. While the registered manager was recruiting to these positions the lack of stability impacted on the care people received.

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

The handyman had left and a new one had been appointed. However, their DBS check had not yet been received and so to facilitate the need of the service to have access to a handyman they had been working as a self-employed contractor. The provider did have a policy in place regarding contractors, However, it did not require that the contractors produce a DBS check that their company certified that contractors were safe to work with people living at the home. Therefore we could not be sure that people were fully protected from the risks of people who were unsuitable to be around vulnerable people.

For staff employed by the home appropriate checks had been completed. A member of staff told us checks made included checking their DBS, references and identification. They said they completed an application form and attended interview. They said they were appointed on a three month probationary period and the manager had provided them with some initial positive feedback and checked on their progress with the mandatory training. The registered manager ensured that all the agency staff who worked in the home had received the appropriate training and had the required checks completed by the agency to ensure that they were safe to work with the vulnerable people living at the home.

At our inspection in August 2016 we identified that the provider had not ensured that risk assessments had been completed to keep people safe and that medicines were consistently managed in a safe way. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment. At inspections in September 2016 and November 2016, February 2017 and September 2017 we found that while improvements had been made the provider had not been able to demonstrate compliance with the legal regulations.

At this inspection we found that the provider had still not ensured that all risks to people had been correctly identified. Staff had an inconsistent approach to assessing risk and some risk assessments did not show consideration of some of the factors influencing the person's risk. For example, some people had a risk assessment for the use of bed rails which did not consider whether the person might try to climb over them or consider the risks of entrapment.

While risk assessments had been reviewed each month we saw that they did not accurately calculate people's risks. For example, we saw that one person was at risk of falling. Their falls risk assessment did not take into account their underlying conditions and so gave a lower risk of falls that the person actually had. We saw their care plan contained details of how to help them to get up following a fall. However, these instructions included rolling the person on to a sheet and using this to put them into a sitting position. This was not best practice for moving and handling. No action had been taken to assess the person for using a hoist. Another example was a person who was having multiple falls and had fallen eight times since our previous inspection, between September 2017 and December 2017. These falls had not been included in the ongoing risk assessments to monitor falls risks until February 2018. Therefore the care did not reflect the needs of the person in order to prevent falls and possible injury.

Staff had also not correctly identified people's risk of developing pressure ulcers. One pressure risk assessment noted that the person was at a medium risk of developing pressure area damage. However, the care plans had not taken into account their current diagnoses or accurately reflected their ability to maintain their continence. This meant that the person was at a higher risk of developing pressure ulcers. There was a skin integrity care plan in place which noted that the person had fragile skin, but there was no equipment or care in place to support the person to maintain healthy skin. Another person's risk assessment had not been updated to show that they currently had red skin on their pressure areas.

When people required assistance to re-position themselves to prevent pressure ulcers, staff kept records of their interventions. However, we saw that on some occasions staff did not people and recorded they were left in the same position between checks. For example, one person's care plans recommended that they be repositioned every four hours. Records showed that on 11 March 2018 they were recorded as being re-positioned onto their right side at 11.25pm and being on their right at 2am, 4am and moved onto their back at 6am. On 12 March 2018 they were recorded as being on their back at 9am, 12pm, 3pm and 7pm and being moved onto their left side at 9.34pm. On 13 March 2018 the person was checked but not re-positioned at 9pm on 13/03/2018 and not repositioned until 6am on 14/03/2018 This meant they were in one position for 12 hours. This increased this person's risk of developing a pressure ulcer.

We also identified that no checks were being completed on air mattresses in place. Air mattresses are used to reduce the pressure on people's skin to prevent pressure ulcers. However, they needed to be set to support the weight of the person. This had not been done and the registered manager told us there were no checks in place to ensure air mattresses remained on the correct setting which could lead to further breakdown of skin integrity. Following the inspection the provider submitted information to show that the air mattresses were checked on a daily basis.

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

We found that the provider had made some improvements to the way that medicines were managed. Medicines were stored safely, securely and in line with guidance to ensure that the medicines remained effective. For example, some medicines were stored in the refrigerator and the temperatures were checked daily to ensure that the refrigerator was working properly.

The nurse was responsible for administering all the medicines in the home. We saw that they administered medicines to one person at a time to reduce the risk of errors. They supported people to take their medicines in a kind way and were knowledgeable about how people preferred to take their medicines. However, we saw that during the medicine round the nurse retained the telephone for the home and needed to answer it multiple times while administering medicines. These interruptions meant that there was an increased risk of errors being made. We saw that the nurse supported one person to take an inhaled medicine. We observed they required two inhalers. Their care plan noted that they may need assistance with their COPD inhaler as they may have erratic movements which make self-administering harder for them. Their risk assessment for their salbutamol inhaler notes that they use it correctly. We saw them take their inhaler and had concerns that they may not be getting the full therapeutic dose of their medicine due to poor use of their inhaler.

We saw that some people were assisted to self-medicate for some rescue medicines such as inhalers for Asthma. However, there was no monitoring in place to see how often they were taking the medicine. This was important to see if the person's condition was stable.

Records monitoring the administration of medicines were fully completed. In addition, where people had been prescribed medicines to be taken as needed, there was clear guidance available to staff on when the medicine should be administered. Where people may need pain relief, records identified if people were able to indicate to staff that they were in pain. However, we saw that the recording of one person's warfarin medicine on the records did not follow good practice. This was important as warfarin affects the blood and an incorrect dosage could leave the person at increased risk of stroke or heart attack.

When we inspected in August 2016 we had identified concerns around cleanliness. At following inspections we noted an improvement in the cleanliness. At this inspection we found there had been a new cleaner employed and a cleaning schedule was in place to support them to reduce the risk of infection in the home. The schedule set out what cleaning needed to be completed on a daily, weekly and monthly basis and records showed that the cleaner was working to the schedule.

In addition, the cleaner was deep cleaning one room a week. They were working through the rooms in the occupied building in numerical order. They had not prioritised the rooms people were using or rooms that had been left dirty when the previous person left. At present there was no formal process in place to hand over concerns to the registered manager but the cleaner told us any major concerns they would raise immediately with the registered manager who would take action. For example, one person's mattress had been replaced.

Staff were aware of the actions they should take if a person presented with an infection such as diarrhoea and vomiting. They said the person would be advised to stay in their room and the amount of contact they had with other people living in the home would be reduced. They told us personal protective equipment (PPE) was readily available and we observed aprons and gloves were available in dispensers on the corridors near the bathrooms and showers.

However, we identified areas in the home which were infection control risks. One example of this was black mould on one of the bathroom ceilings. The extractor fan was not working in this bathroom making the room warm and humid creating an environment where mould would grow. The mould could be hazardous to people's health and cause infection. The registered manager arranged for a new fan to be fitted during the inspection and the mould washed away. However, this would not resolve the problem as the mould would reappear and action was needed to kill the fungus.

In addition, we saw that when people moved out their rooms had not been cleaned to a standard that would reduce the risk of infection. We saw one room that had been empty since September 2017 still had bird seed and feathers there from the person's pet birds. The feathers may have contained diseases and the seeds could encourage vermin into the home. We saw that another person had moved out of a flat. We saw that all the furniture and carpets had been removed from this room. However, no deep clean had been completed. The room smelt strongly of urine and there were flies in the room. There were no current plans in place as to when this flat would be properly cleaned and so conditions would continue to deteriorate.

The registered manager was aware of their responsibilities for safeguarding people living in the home. CQC were informed of safeguarding concerns and a record was kept of the outcomes of safeguarding investigations.

Staff were aware of the signs of abuse and they said they would raise any concerns with the nurse or the manager. One member of staff said they had reported some concerns previously and the registered manager had acted immediately and they felt it had been resolved satisfactorily. They said the contact numbers for reporting safeguarding concerns externally were displayed in the nurses' office. The nurse was

aware of the role of the safeguarding team at the Local Authority and was familiar with the process.

Staff told us they were encouraged to report incidents and a member of staff said, "They always take notice." They said that even when they reported a minor issue in relation to a person's care the nurse went to review the person's needs and took action. However, we saw that robust action had not always been taken to keep people safe from nationally identified problems. A medical devices alert from February 2015 had highlighted the risks of thickening powder following an incident where a care home resident had died. We observed a tin of thickening powder was left in the lounge by jugs of soft drink. This was a risk as it was available for everyone to access and some people living at the home may not understand the risk. The registered manager confirmed that they received medical device alerts.

Inadequate

Is the service effective?

Our findings

When we inspected in September 2017 we identified concerns to the environment both inside the home and in the grounds. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations Premises and equipment.

At this inspection we found that the home was registered to provide care for 80 people and the service was provided across two buildings. However, one of these buildings was empty and the registered manager told us that it had recently been vandalised and was no longer fit to be occupied. We looked around this building and could see that copper pipes had been removed and radiators were not connected. In addition, the skirting boards had been removed and electrical wires were hanging from the walls.

There had been some action taken from our last inspection. For example, corridors had been painted and the lighting issue in the corridor for the flats had been resolved.

At our last inspection we had raised concerns as rooms did not support people's needs. One person had a steel beam for a hoist approximately four foot above their bed. The beam was intrusive and ran the whole length of the room. We saw that this was still the case at this inspection. The registered manager told us that they person had not wanted to move to a different bedroom. However, there was no documentation to show that any discussions had taken place with the person to discuss the possibility of moving to a room which better suited their needs. The RM confirmed that there had also been no risk assessment completed in relation to this matter.

The provider had not ensured that the windows were all in working order. Some of the windows had been secured by placing a metal strip from the window to the frame. This meant that these windows would not be able to be opened at all. This made the window look unsightly. In addition, window restrictors had not been fitted to all the windows. We had raised concerns at the last inspection that window restrictors were not in place and the provider challenged this concern and assured us that restrictors were in place on all windows.

At our last inspection we found that the outside area was not well maintained. At this inspection we found that minimal action had been taken to improve the external environment. For example, we saw that some shrubs had been cut down to improve access to the paths. However, most of the concerns we had previously identified were still in place. For example, a patio area just off the activity room was left untidy with a ride on lawn mower left to sit on the patio. The area had not been maintained and weeds had grown up between the paving slabs making the area inaccessible for people using mobility aids or wheelchairs. In addition, we saw the slabs in one path had become uneven making it impossible for a wheelchair to access.

The smoking shelter was not adequate. We identified this concern at our last inspection and no action had been taken to improve the facilities for people. It had two chairs in it and was uninviting. It did not provide enough shelter for people in wheelchairs to use.

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

Regulations Premises and equipment.

At our inspections in August 2016 and September 2017 we identified that the provider had not ensured that people's capacity to make decisions had been suitably assessed and that all of their legal rights would be maintained. In addition, they had not ensured that the legal requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) had been correctly implemented. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Need for consent.

We still identified concerns around people's consent at this inspection. 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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the home was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Three people living at the home had a DoLS in place to restrict their liberty as they were unable to safely access the community unsupported.

People now had some mental capacity assessments in place to show which decision they were capable of making and which decision they needed support to make. However, we found some instances where mental capacity assessments were still needed. For example, a continuing healthcare assessment noted that a person may be unsafe in the community on their mobility scooter. The assessment also noted that while a DoLS had been refused they were unsure if the person understood the risks involved in taking their scooter out in the community. No MCA assessments had been completed for this person, the care plan noted that the person had capacity. The MCA is clear that if there are concerns about a person's capacity then each decision needs to be assessed on an individual basis.

There was also a lack of recording on how decisions had been made in people's best interest. There was no record of who had been involved in making the decision, what options had been discussed and why the option chosen was best for the person.

We saw that some people at the home were taking covert medicines. We saw that there was an appropriate best interest decision in place around the covert medicines. However, we saw that while their medicine was put in their drink, they knew it was there. They were inappropriately offered cigarettes as a reward to drink the medicine. This was not appropriate and placed a restriction on the person if they refused their medicine. This care was also not recorded in their care plan.

This was a continuing breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) regulations Need for consent.

Care records contained consent forms to allow staff to use photographs in their care records and for allowing other professionals access to their care records. In one of the records we reviewed, the person had signed the form, whilst in another there was a record that the care plan had been discussed with the person and their close relative and the relative had signed on their behalf as they were unable to. In the third record

staff documented the person was unable to sign but had provided verbal consent.

At our inspections in August 2016, February 2017 and September 2017 we identified concerns with the level of knowledge and skills of the staff in the home and the support they received to carry out their roles.

New members of staff completed an induction to the home. This included completing training and shadowing a more experienced member of staff. In addition, new staff were required to complete the care certificate if they had not already done so. The care certificate is a set of national standards which ensure that staff have the skills needed to provide the basic care safely. A newly appointed member of staff said they were working their way through the mandatory training and had completed most of the modules. They said they were given a good induction and were able to shadow an experienced member of staff. They said that although they had now worked at the home for over a month they were always rostered with an experienced member of staff. They said it was easy to ask questions and staff took the time to explain.

In relation to additional training a member of staff said they were the link for infection prevention and control and were able to attend network meetings. They said they brought back information for the rest of the staff which was displayed on noticeboards. They said that if they identified that there were issues with practice they would be able to raise it and changes would be made.

A nurse said their clinical skills were up to date when they moved to the home and if they identified a training need they would be able to discuss this with the manager. They were confident they would be given the opportunity to attend training they required.

A supervision matrix was displayed in the nurse's office which showed the planned dates for supervision for each member of staff throughout 2018. All staff was rostered for four supervision sessions and an appraisal.

However, despite all the training being in place we identified areas of concern where staff's skills did not reflect the latest best practice or guidance. For example, risk assessments and care plans did not support people's needs. Concerns were identified around the dignity of some people and staff had not recognised the concerns or changes in people's care needs. In addition, the registered manager had not consistently assessed staff competencies with only a small number of competency assessments being completed despite this being identified as an area for improvement by an external consultant in January 2018.

The provider was now meeting the breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) regulations in relation to providing training and supervision.

People told us they enjoyed the food and they were able to choose from different options. They were happy with the food provided and said they were offered plenty to drink. The kitchen staff said people were able to choose between two main meals for lunch. The chef was notified about people like and dislikes and any allergies they had.

People's ability to eat and drink safely was monitored and people were referred for assessment by a healthcare professional when needed. However, care plans contained contradictory information regarding the consistency of food needed to reduce the risks to people while eating. People's ability to maintain a healthy weight was monitored. One person living at the home was on supplements to help them maintain a healthy weight. Where needed, adapted cutlery and crockery was available to support people's independence.

People's health needs were monitored and people were supported to access healthcare professionals such

as the doctor and district nurses. In addition, a consultant from the NHS rehabilitation service visited the home to review some people as required so that they did not have to make a hospital visit. We saw evidence people had regular access to a dentist, chiropodist and optician.

However, we spoke with a person who said they spent their time in bed as their wheelchair was very uncomfortable and exacerbated their pain. We saw that they had been reviewed by a rehabilitation consultant in September 2017 who referred the person to a surgical consultant. As the inspection took place in March 2018 we asked the registered manager about this and they were unsure of the position as to further action. After we raised the concern with them they chased the referral with the hospital. We were concerned that the person's referral was not monitored by the staff and would have gone unrecognised if we had not intervened.

There was very little evidence of health promotion activities. We did not see any information about healthy eating or smoking cessation. Some people consumed excessive alcohol at times and staff took some measures to support them to limit their alcohol consumption, but we did not see any evidence of any health education to support the person to make this decision for themselves.

Care and support did not always reflect current evidence-based guidance, standards and best practice. The provider had chosen to use an adapted tool to measure people's risk of skin sores rather than an accredited version. The registered manager and regional manager were unable to tell us why they thought that this adapted score was used or why it was an appropriate measure for people living at the home. They told us that they would review the use of the tool. In addition, we saw that the registered manager had not ensured that staff had consistently used the current evidence base when assessing risks. For example, some people's risks around the use of bed rails did not reflect the current Health and Safety Executive guidance such as assessing the risk of a person climbing over the rails. Infection control standards were not being met in the empty rooms we saw guidance on the removal of mould had not been followed.

In addition, care assessments did not consider the full range of people's diverse needs. For example, some of the people living at the home were living with an acquired brain injury. While care plans reviewed people's needs there was no consideration of how the acquired brain injury would affect the person or the additional support they may need.

Requires Improvement

Is the service caring?

Our findings

At our inspection in August 2016 we identified that people's dignity was not fully protected. When we inspected in February 2017 and September 2017 we found that the action taken had still not fully supported people's dignity.

At this inspection staff were able to describe the steps they took to preserve people's privacy and dignity during personal care such as closing doors and curtains. However, people's dignity was not fully supported. We saw that people had not been supported to maintain their appearance to a socially acceptable standard. In addition, they were not supported to maintain what their care plan stated was their normal standard of appearance. For example, one person's care plan noted that they liked a shave every other day and to keep their hair short. We saw that this person had a beard and long hair. We discussed this with a member of staff who commented that the person had become aggressive when receiving personal care. However, no exploration had been completed into why this person's behaviour had changed and their care plan had not been updated to show that there had been a change in their habits.

One person's wheelchair had a latex glove tied around the footplates. We asked a member of staff about this. They explained that the person's wheelchair was in need of attention as the footplate would not stay in position. They said that a colleague had tied the two footplates together with a latex glove so that they footplate did not move. This did not support the person's dignity. Another person told us how they always had to wait for care as the staff did not ensure that their hoist was charged and ready for use. They told us that they experienced regular delays to their care because of this.

In addition, we saw that changes to the environment had not been completed in a way which supported people's dignity. At our last inspection we found that the carpet on the fire escape was loose and a trip hazard. At this inspection we found that registered manager had taken action and the fire escape was now safe. However, this had been achieved by removing cutting away the loose carpet and left a cut edge on display. In addition, the carpet at the bottom of the stairs had been removed but the underfelt had been left. Furthermore paint had been left on carpets around the building following the recent re-decoration.

Care records indicated people were involved in discussions about their care. For some people key parts of their care plans and other information about the home had been translated into their first language to support them to access their information. However, a recent consultant's report indicated that the person may benefit from a translator and this may have a positive Impact on their involvement in their care plans. The registered manager told us that they had not accessed a translator at this stage. They explained that a new member of staff did speak a different language that the person was able to use to translate but no action had currently been taken about engaging them in their care plan.

During our inspection we saw that people were able to walk freely around the home and were able to choose where to spend their time. Some action had been taken to help people engage with the home and their care choices. For example, there were pictures of the daily menu on the wall and the weekly menu was on display and the activities board had been lowered to make the information more accessible to people in

wheelchairs. In addition, people living at the home had created a dignity tree showing what was important to them in maintaining their dignity.

A recently appointed member of staff said they really enjoyed working at the home as the staff were all very good. They said they showed kindness and understanding for people they cared for. We observed staff interacting with people and saw that staff were kind and caring. People felt comfortable with the staff and looked to them for comfort and support. For example, we saw one person reach out to hug a member of staff and they kissed the member of staff on the cheek to show their affection.

Requires Improvement

Is the service responsive?

Our findings

When we inspected in August 2016, February 2017 and September 2017 We found shortfalls in care planning had not supported people's needs.

At this inspection we found that people's care records contained individual care plans for most aspects of their care and support, However, the detail provided was variable and some lacked information on elements of their care. For example, a person with epilepsy did not have an epilepsy care plan and when people were incontinent it was not always clear how this was being managed. Another person was taking a medicine which made them more likely to bruise easily and for it to be harder to stop the bleeding if they injured themselves. There was no mention in their care plan of this medicine and no information for staff on their skin assessment form to look for extensive bruising.

Care plans were evaluated monthly but did not always document information needed to assess the person's current requirements. For example, a person had a care plan which described behaviours the person had which others may find challenging. However, the evaluation did not state how often or if the person had showed these behaviours within the evaluation period. The person's risk assessment stated they sometimes threw crockery when they were frustrated. We asked the manager why melamine or non-breakable alternatives were not considered. They told us the person refused to eat from them and had not exhibited this behaviour for a considerable time. We would not have been aware of this from their care record.

Some care records contained conflicting information, making it difficult to be sure of people's current needs. For example, a person's dietary needs care plan stated they had been assessed by a speech and language therapist and they were able to have normal diet and fluids, but that their food should be cut up and they should be sat upright at mealtimes. However, a choking risk assessment stated they required a modified texture diet, and the handover information stated they required a fork mashable diet. We observed the person eating sausages cut into chunks and vegetables at lunch time. We saw in another person's care plan that there was conflicting information in place about the action staff should take if they refused their medicines.

Records showed one person had been referred to a rehabilitation consultant because their wheelchair was uncomfortable. The consultant indicated that there were options to improve their situation which included surgery but that the person would need to lose some weight prior to surgery. The person was still waiting for their appointment to see the surgeon as the staff had not followed the appointment up in a timely fashion. We did not see any evidence in the person's care record that action was being taken to support the person to lose weight.

Some people living at the home were living with alcohol misuse. Their care plan noted that they had the capacity to make the choice to drink and that they had discussed their drinking with the registered manager and chose to continue drinking. However, we saw that this person was having regular falls when intoxicated as well as other personal care issues which may impact on their health. There was no care plan in place about how the person's drinking was going to be monitored and how often advice and education around

alcohol was going to be offered. A member of staff told us that they nurse would remove alcohol from a person if they were intoxicated. However, this was not reflected it their care plan.

The nurse on duty told us that one person would go around the car boot sales held near the home and that their behaviour would lead them to steal from the stalls. There was no care plan in place around this and no action taken to keep this person safe from their impulses. Their care plan noted that they only accessed the home's grounds on their own. However, an assessment completed for continuing health care funding noted that there was some challenging behaviour which was a risk to self and others. For example, it noted that the person would go out into the community and cause a risk to themselves and other road users.

This was a breach of Regulation 9 of the Health and Social care Act 2008 (Regulated Activities) regulations 2014 person centred care.

There was no one at the home at the end of their life. People had end of life care records which stated whether they had made a decision about whether they wanted resuscitation to be attempted. Information was also available about who should be consulted in decision making when the person was nearing the end of their life.

There was no dedicated activities staff but the registered manager told us that activities were provided by the staff on shift between 2pm and 4pm. Staff confirmed this and said that they would look on the notice board to see what activities had been planned. However, staff told us that while everyone was asked to join activities a lot of people chose not to. When people chose not to join in activities staff told us they tried to spend time with them on an individual basis. We saw that one person's care plan noted that they liked to be sociable but now found this difficult. There was no care plan in place on how staff could work with the person to increase their access to appropriate social activities.

We saw staff playing skittles and ball games with people in the afternoon of the inspection. People had access to a snooker table and we saw one person taking advantage of that. There were assorted games on a table in one of the communal areas. Staff told us they had access to monthly armchair exercise classes and ball games. A basketball hoop and ball was provided for people.

One person living at the home liked to watch films on their tablet computer. However, their Wireless signal did not reach their bedroom. This meant that the person had to sit in the communal area to watch films.

There was no dedicated staff time to support people to access the community. Four people were receiving additional support from an external agency to support them to access the community.

There was information on how to raise a complaint on display in the entrance hall. People told us that they were happy to raise complaints and would raise them with the staff or the registered manager. Staff said if someone wanted to make a complaint or raised a concern they would try to resolve it and report it to the manager. They said they received feedback from the manager when they needed to change the way things were done. The registered manager told us that they had received no complaints since our last inspection.

Inadequate

Is the service well-led?

Our findings

At our inspections in August 2016, February 2017 and September 2017 we identified that the provider had not ensured that quality assurance systems were reliably managed to ensure that they identified and resolved shortfalls in the care provided for people. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance.

At this inspection a member of staff said the manager was very clear about the vision and strategy for the home. They said they had spoken about improving the quality of care and the CQC rating, improving the environment and improving staff training. They said the management team had "Put a lot of effort into staffing and improving care." A nurse said they had been fully informed of the challenges faced by the home when they accepted a permanent role. They said over the past six months systems had been put into place to improve the quality of care and monitoring. These included regular supervision for staff and improved staff induction. They said some staff were still reluctant to speak up when they were struggling or had problems. However, they were working hard to change the culture and enable staff to realise the home was taking a supportive approach. They said care plan reviews were taking place and other quality monitoring was being undertaken by the registered manager.

However, we found that these systems were not fully effective and that not enough improvements had been made to ensure compliance with the regulations. There were more audits in place to monitor the quality and safety of the care provided to people. However, we could not be assured that they were effective. During the inspection we identified concerns with the quality of the risk assessments and care plans and despite some care records containing evidence of care plan audits having been completed none of these concerns had been identified.

Safety concerns around the environment had not been addressed. We identified concerns that windows were not restricted to keep people safe. The provider told us that the registered manager had sent an audit assuring them that window restrictors were fitted to all windows. However, on the day of inspection we found several windows which needed attention. In addition, we saw that an external company had audited the home in January 2018 and had identified the same concerns regarding the window restrictors and no action had been taken.

In addition, we saw that action was not taken to ensure that equipment was serviced and safe to use. The engineers had visited the home the hoists on 19 January 2018. However, records showed that they were unable to service and certify some of the equipment as safe. Three hoists had been unable to be tested as their batteries had been flat at the time of the visit, with a further hoist unable to be tested as the power pack was not working. Two further hoists had been labelled as do not use. Of the equipment able to be used, two pieces needed further attention, The bath hoist was rusting and paint was bubbling away and a handset for another hoist was damaged but still worked. We saw a hoist was in use which did not have evidence of a service.

We saw that the provider had commissioned two external companies to completed audits in relation to the

quality of the care and environment. We saw that they had identified areas for improvement. The registered manager had taken some action following these audits. For example, they had fixed concerns raised about individual care plans and had taken action regarding the fire alarm checks. However, effective action had not been taken to improve the quality of the care or environment following these audits. For example, one report had noted that the air mattresses in place had not had checks, assessments or care plans and we identified the same concerns. The second report raised concerns regarding the quality of the best interest decisions and again we found the same concerns.

The building was in need of attention and refurbishment. The provider and registered manager showed us that they had a refurbishment plan in place. This was not an effective refurbishment plan and only covered the work needed in the next three months. In addition, we saw that it did not prioritise improving the experience of people living at the home. But instead identified that the manager's office needed decorating, empty rooms needed making ready to be occupied and that work was needed on the empty building. The only work identified that would impact on people was to start clearing up the outside. We saw that the refurbishment plan did not reflect actions identified in the consultants reports.

The provider had complied with the regulations of the Health and Social Care Act 2008. They had notified us about all the incidents in the home and had displayed the latest rating. However, we saw that the provider and registered manager had not taken action to ensure that they complied with the law regarding the need to have Employers Liability insurance. The certificate on display had expired in January 2018. We asked the provider for a copy of the new certificate. The start date for the new insurance was 16 March 2018, two days after our inspection. The provider was then able to submit a second certificate to show that they had been able to backdate the insurance from 4 January 2018.

As well as employers liability the new insurance also covered public liability. This meant that if staff, people living at the home and visitors had an accident on the site the provider may not have had access to funds to pay our compensation. We were concerned as we identified areas where health and safety guidance was not being adhered to and this increased the risk of incidents and injuries occurring. We have referred this matter to the Health and Safety Executive.

The registered manager told us that they kept up to date with changes in legislation and guidance. However, during the inspection we found that the provider's, registered manager's and staff's views of good quality care did not reflect the latest guidance or evidence based practice. A member of staff told us, "It took us a while to get used to the manager, but now we know her and understand her ways, it has been very positive." They described the home as being completely turned around. However, we identified concerns that care fell below what people should reasonable expect. Risk assessments were inconsistent, did not reflect people's needs and were not always classified using evidence based assessment tools. In addition. care plans did not ensure that the care provided followed best practice or advice from other health care professionals.

This was a continuing Breach of Regulation 17 of the Health and Social care Act 2008 (Regulated Activities) regulations 2014 Good Governance.

Staff said they had monthly staff meetings. They said there were a number of agenda items and then staff were free to raise issues themselves. They said some staff were "not slow to bring up issues", but the registered manager tried to resolve issues and act on feedback. Staff were not always aware of where to find the minutes of the meetings if they had been unable to attend.

A member of staff said they thought the home had changed a lot over the past six months. They said the people seemed happier and they felt this was a reflection of the staff's attitude and the staff morale. They

said, "If we are happy, they are happy."

A member of staff said that residents and relatives meetings were held and they gave examples of issues which had been raised and were addressed. This included updating the décor and providing a basketball hoop and ball.