Amore Elderly Care (Wednesfield) Limited

Bentley Court Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Bentley Court Care Home is a residential care home providing personal and nursing care for up to 77 people aged 65 and over. At the time of the inspection there were 48 people who were living at the service, many of whom were living with dementia. The service has a specialist dementia unit which was home to 18 of the people who were living at Bentley Court Care Home during the inspection.

People's experience of using this service:

People were not sufficiently protected from the risk of harm; including potential abuse, the behaviour of others, health concerns or accidents and injury. The provider's risk management systems were inadequate. People were not protected by consistently safe medicines management systems.

People were not supported to have maximum choice and control of their lives and staff did not consistently support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not fully support this practice.

People's needs were not being accurately assessed, understood and communicated. The quality of care in the service was inconsistent. Some people's health and nutritional needs were met while some were not. Some interactions between staff and people were also of a high quality while others were not. The provider had not ensured support given to people was consistently caring and respectful and that people's choices were promoted as far as possible.

People's personal preferences and needs were not always fully understood and planned for. As a result, care did not always fulfil people's needs. Care provided did not consistently meet people's needs. People were not receiving care that was truly person-centred; including around personal care, leisure opportunities and meaningful activities.

People were not protected by robust quality assurance and governance systems. The provider failed to ensure the systems they had in place identified risk to people and areas of improvement needed. The provider failed to make sufficient improvements and as a result people were living in a deteriorating service and were exposed to the risk of harm.
Rating at last inspection (and update)
The last rating for this service was inadequate (report published 12 March 2019). This meant the service was entered into special measures. The provider was not meeting the regulations around staffing levels, person-centred care and good governance.

At this inspection we found sufficient improvement had not been made and the provider was still in breach of regulations. This service has been rated as requires improvement or inadequate for the last five consecutive inspections.

Why we inspected
This was a planned inspection based on the previous rating but was prompted in part due to concerns about the management of risk in the service, including the management of risks associate with behaviours that can challenge others. The inspection was also prompted in part by notification of specific incidents; following which a person using the service sustained a serious injury and another died. The information CQC received about the incidents indicated concerns about the management of risk and the management of specific health concerns. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We have identified breaches in relation to safe care and treatment, safeguarding, the need for consent, person-centred care and good governance.

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.

Follow up
The overall rating for this service is 'Inadequate' and the service therefore remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

Bentley Court Care Home

Detailed findings

Background to this inspection

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

Inspection team
The inspection team consisted of two inspectors, an assistant inspector, a Specialist Advisor and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The Specialist Advisor was a qualified nurse.

Service and service type
Bentley Court Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

Notice of inspection
This inspection was unannounced.

What we did before the inspection
As part of the inspection we reviewed the information we held about the service. We looked to see if statutory notifications had been sent by the provider. A statutory notification contains information about important events which the provider is required to send to us by law. We reviewed information that had been sent to us by the public, commissioners from the local authority, the local authority safeguarding team, the local clinical commissioning group (CCG) and the police.

We also used the information the provider sent us in the provider information return. This is information

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

We used all of this information to plan our inspection.

During the inspection
During the inspection we spoke with six people who used the service and 11 relatives. Many people who lived in the service were unable to share their views regarding the care they received. To help us understand the experiences of these people we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people living at the service. We also carried out further observations across the service regarding the quality of care people received.

We spoke with the registered manager, the Operations Manager, Quality Director and Quality Manager. We spoke with 16 staff members including the cook, the activities co-ordinator, domestic staff, nursing staff, care team leaders and care staff. We also spoke with two healthcare professionals who were visiting people living at the service. We reviewed records relating to people's medicines and 21 people's care. We also reviewed records relating to the management of the service; including staff recruitment records, complaints and quality assurance records.

After the inspection –
We continued to seek clarification from the registered manager to validate evidence found. We looked at training data and quality assurance records.

Inadequate

Is the service safe?

Our findings

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

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

Systems and processes to safeguard people from the risk of abuse

- People gave us mixed views around how safe they felt in the service. One person told us, "I'm relatively safe". A relative told us, "I feel [my family member] is safer since the new manager has come. She is new, whether what she is doing now will die off time will tell".
- Staff we spoke to were able to describe basic signs of potential abuse and how they would report abuse. However, we found they did not have an in-depth understanding of how to identify abuse. In practice, not all concerns were being reported to either the registered manager or the local safeguarding authority.
- While the registered manager had reported concerns they were aware of to the local safeguarding authority we identified safeguarding concerns that had gone unreported. For example, incidents involving service users displaying sexualised behaviour towards others and unexplained bruising. Reporting systems had failed; therefore the registered manager had not been informed and the concerns were not reported to the local safeguarding authority.
- We also identified examples of where the registered manager had been informed and actions to minimise against the risk of future harm were insufficient. People had been unnecessarily exposed to the ongoing risk of harm due to poor risk management and safeguarding systems.

The provider's failure to ensure that all safeguarding concerns were identified and reported was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment

Assessing risk, safety monitoring and management; Using medicines safely

- People gave mixed views around how well risks can be managed and this was reflected also in the discussions we had with relatives. For example; one person told us staff did not always respond quickly to their call bell. A relative said, "There is no call bell in the room. There is a sign saying 'I am unable to use the call bell independently. Please ask me if I need assistance.' I worry about that, [person's] not a shouter so if [they] needed help I don't know what would happen". We saw that regular checks were completed for this person, but they were not effective. We found care staff had recorded no issues when this person was visibly distressed, and a doctor was required. Care staff were also unaware of the potential risk to this person, the detail of the observations they should be making and how they should be protecting the service user from harm.
- People were not always supported to move in a way that protected them from the risk of injury. We saw two people being mobilised in chairs with their feet dragging on the floor. We also saw another person being supported to stand by staff pulling them up with their arms. This increases the risk of injuries such as shoulder dislocation. The person's care plan outlined equipment was required that staff had failed to use.
- While we found overall the registered manager had reduced the number of falls occurring within the

service, we identified people where the provider had failed to identify risks associated with people's failure to use, or to ensure the availability of equipment. For example, one person was not using a walking frame, had experienced falls and staff had failed to fully consider the risk and take steps to minimise this as far as reasonably possible. Another person had a serious injury from a fall and staff had not considered risks associated with them mobilising independently without their glasses. This risk was explored by the provider following the inspection and it was confirmed unlikely the lack of glasses contributed to the fall. The provider has committed to ensuring similar risks are fully considered and risk assessed in the future.

•□People were not always protected from risks associated with wounds and skin integrity. For example, we identified one person had a large wound and insufficient action had been taken to identify the cause or to provide appropriate treatment. We found further examples of where insufficient action had been taken to either prevent wounds or to promote healing. We also found examples of where people's pain in relation to their wounds had not been considered and managed.

•□People were not protected from risks associated with behaviours that could challenge others. While we found there had been improvements in the number of reported incidents, we found that not all incidents arising were recorded and reported. We also found plans and risk assessments did not provide sufficient guidelines for staff around how to identify triggers of behaviour and how to proactively manage any incidents arising. We found one person had been involved in physical altercations with other people living at the service and clear guidance had not been developed to assist staff in proactively managing the risk.

•□People were not sufficiently protected from risks associated with their diet and nutrition. For example, one person had been insufficiently protected following an incident where they had choked on food. Following this lack of action, the person experienced a second choking incident.

•□We found overall risks associated with weight loss were managed well for people although this was inconsistent. For example, we found one person had lost over 10kg in five months, yet insufficient action had been taken. A care plan was in place that outlined interventions staff should take in the event of weight loss and this action was not being taken. The person's food and fluid intake were not being monitored, support was not being offered and assistance had not been sought from healthcare professionals. Staff told us this person lacked capacity to understand they may be at risk from weight loss and appropriate action had not been taken to protect them.

•□People were not always protected from the risk of harm associated with poor medicines management. For example, some people were prescribed sedating medicines on as 'as required' basis. There was insufficient evidence to show these people received their medicines appropriately, only when needed and as a last resort. We found people's pain was not being monitored proactively and pain relief prescribed on an 'as required' basis had not always been given to people who appeared to be visibly in pain.

•□We found risks associated with the management of diabetes were not always managed. One person required specific actions to be taken if their blood sugar levels were over a specified level. Staff had failed to take these actions, despite them being outlined in the person's care plan. This put the person at an increased avoidable risk of a diabetic emergency.

•□People were not protected from health risks associated with poor dental hygiene. Despite people appearing to have poor dental hygiene we found the provider was not able to confirm when 46 out of the 48 people living at the service had last seen a dentist. We saw oral care records stated that people were not receiving regular oral care by staff, including one person who had been diagnosed with an oral health condition. This person's condition could be worsened and is less likely to heal quickly if they are not maintaining good oral hygiene.

•□People were exposed to the risk of harm due to poor communication systems resulting in staff not being aware of changes in people's health. We found one example of where someone had seen a doctor who had diagnosed two conditions and provided medicines. Staff we spoke with the following day were not aware of the doctor's visit and the diagnosis given and were unaware of any signs they should be observing of a deterioration in the person's health.

The provider's failure to ensure risks to people were sufficiently understood and managed was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment

Learning lessons when things go wrong

•□We found the registered manager was implementing systems with the view to learning lessons from incidents arising within the service; for example, incident debriefs called 'safety huddles'. We found these systems were not yet effective. Reporting systems within the service meant the registered manager was not always informed of incidents that required a debrief.

•□We saw some examples of where positive risk mitigation was put in place to protect people as a result of the incident debriefs. Although, we also found examples of missed opportunities to safeguard people and to protect them in the future. As a result, certain subsequent incidents may have been unavoidable.

Staffing and recruitment

•□At the last inspection we found the provider was not meeting the legal requirements around the numbers of staff available within the service. At this inspection we found staffing levels had improved within the service and the basic legal requirements were met. However, further improvement was still required.

•□Most people were not able to share a view around staffing levels although one person told us, "The staff are busy. They could do with more". Relatives told us they felt more staff were needed. One relative told us, "There is not enough staff. Particularly not at weekends." Another relative told us, "There are not enough staff. A few residents have had falls". A third relative told us, "I think they have only got enough staff to cover the legal requirements".

•□We saw the registered manager had reviewed staffing levels and was using a structured system to assess the staffing levels within the service. They were meeting the staffing requirements as defined by this system although the system was defined by the dependency levels of individual people. As not all incidents arising in the service were known to the registered manager they had not based dependency assessments on a full picture of people's needs and demands on staff. As a result, the provider could not evidence this system had been accurately calculated.

•□We saw sufficient numbers of staff within the service. However, poor deployment and skills meant that people's needs were not always being met responsively and effectively.

•□People were protected by safe recruitment systems that ensured staff members were screened appropriately prior to commencing work at the service with vulnerable people.

Preventing and controlling infection

•□While people were not able to share their views around the cleanliness of the service, relatives told us they had found improvements. One relative told us, "It's cleaner now. The staff seem a bit more aware. Another relative said, "It is clean. You still get some smells and that's not nice, but there are less smells now".

•□We found the service to be clean and staff were observing good infection control practices.

•□People were protected by appropriate infection prevention and control systems and policies. We also saw regular checks and audits were being completed.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

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

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- People who had capacity to consent to specific decisions told us staff did consult them and ask for their consent. One person told us, "[Staff] ask me what I want doing". Staff we spoke to had a basic understanding of the purpose of the MCA and had been given prompt cards they could refer to while supporting people. We found some decisions had been considered in line with the MCA where people lacked capacity. However, this was not consistent, and we found significant examples of where people's rights had not been upheld.
- Relatives gave us examples of where decisions were made on behalf of people and the principles of the MCA had not been followed. This included cutting someone's hair while they were asleep and the use of covert medicines. Medicines are administered covertly when they are disguised in someone's food or drink without the person's knowledge.
- We found where changes to people's diets had been made and they were unable to consent, the decision had not been made in line with the MCA. We identified people who were on healthy eating plans to lose weight or were on texture modified diets. Their capacity around this decision had not been tested and there was no record of how the decision had been made in the person's best interests.
- We found you had not considered people's capacity when their safety was at risk, for example due to incidents involving challenging behaviour or falls. We found incidents involving sexualised behaviour and people's capacity to consent had not been fully considered. We also found where they were not using equipment such as walking frames, the person's capacity had not been considered and decisions made in line with the MCA to manage risks.
- We found in some cases equipment was in use such as sensor mats or stair gates on bedroom doors. While the MCA had been followed for some people this was not consistent. Equipment was being used for

some people who could not consent without the requirements of the MCA being met.
•□We also identified some examples of where the use of covert medicines had not been fully considered. For example, the decision was made for one person who lacked capacity without a relative or other representative, such as an advocate, having been consulted.

The provider's failure to ensure people's rights were upheld was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Need for consent

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
•□People who were able to share their views told us they felt they could access healthcare professionals when needed. One person told us, "The doctor visited due to being depressed". Another person told us, "Chiropodist comes every two months. Ordered new glasses which are due to come". Relatives told us staff were good at seeking advice in an emergency. One relative told us, "[My family member] has seen a doctor. [The nurse in charge] sends for the doctor". Another relative said, "[Staff are] very good at getting doctor or they call 999".
•□We found the practices within the service were inconsistent. We found the provider had records of when people last seen some healthcare professionals such as the chiropodist and optician. However, people were not regularly seeing a dentist and we saw examples of poor oral hygiene.
•□We saw that referrals were made to the doctor or other healthcare professionals such as nutritionist or Speech and Language Therapists (SaLT) although this was inconsistent. We saw an example of a person with a large wound that had been present for several months and caused the person irritation, yet insufficient medical advice had been sought and an effective treatment plan was not in place. We also saw an example of where nutritional advice had not been sought following weight loss. Where the doctor had been involved, communication systems did not effectively ensure that all staff supporting the person understood their diagnosis and recommended treatment plan.

The providers failure to ensure that all healthcare issues were appropriately addressed form part of the breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
•□We found the registered manager was making improvements to the assessments of people's needs and the quality of care planning had improved, although further improvement was still needed. We found the quality of assessments across the service was inconsistent. Some people's needs were understood in some aspects of their care yet in others this was not the case. People's complex needs in some cases remained misunderstood; in particular where there were issues such as for example challenging behaviour, distressed behaviour and mobility issues.
•□People's care was not always being delivered in line with their care plans and risk assessments.

Staff support: induction, training, skills and experience
•□People gave us mixed views about the skills of the staff team and concerns were raised about the quality of the skills of agency staff. One person told us, "Sometimes [agency staff] make mistakes. I have to tell them how to position me in bed, most staff know how to help you. [There's] quite a few agency staff". A relative told us, "The agency staff are inconsistent".
•□The registered manager told us the use of agency staff had reduced and the agency staff that worked in the service were regular to promote quality and consistency. Despite the agency staff being regular workers within the service we found their skills and competency were not treated in the same way as permanent

staff. For example, the registered manager was only able to produce training records for permanent staff members. They were not able to evidence the ongoing training and development agency staff were receiving. One relative told us, "The issue of agency staff comes up time and time again. They have been using less agency recently".

•□Staff told us they felt training had improved since the new registered manager had started. One staff member told us, "Training is great!". Staff also told us they were starting to have one to one meetings with their line manager and felt they were now well supported.

•□We saw the registered manager was working on training and development of the staff team and were assigning regular training for completion in addition to assessing the competency of staff. Further improvement was still needed and we found systems around training were not yet effective. For example; we saw significant skills gaps in some areas such as moving and handling, dementia care, behaviour management and pain management.

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

•□People told us they were satisfied with the quality of the food they received. One person told us, "The food is nice. My favourite is fish and chips. I get that here. It can be different from one or two or three choices". Another person told us, "Food is fantastic. One good thing… if you want can have a second helping".

•□Relatives and staff both told us improvements had been made to the choices people had. One relative told us, "The food has gotten better. They used to bring [person's name] slop". We were told by relatives and staff how fluids were offered more frequently and how 'treats' had recently been introduced. One relative said, "There are treats like crisps, marshmallows, fruits. That has been in the last couple of weeks. None of that was on display before".

•□Some relatives told us there were inconsistencies in how good staff were at offering fluids and snacks depending on whether management were present. One relative told us, "The staff offering drinks [today], that doesn't usually happen". Another relative told us, "[People] get offered [snacks] when the care manager is there or like now when you are here".

•□We saw the quality of the food was good and the cook had a good knowledge of people's individual needs. We found some good examples of people's nutritional needs being met but we also found examples of where they were not. For example, staff understanding around how to manage weight loss where people had a high BMI needed to be improved.

•□We saw fluid charts were being monitored and drinks were being offered during the inspection. The inspection was completed on two very hot days and we saw extra steps were taken such as offering people ice lollies to aid with hydration.

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

•□People we spoke with were not able to share their views about the building and how well it met their needs. Relatives commented on improvements being made to the garden.

•□The registered manager and the staff team told us about plans that had been shared by the provider regarding refurbishment of the service. They also told us about plans to move the dementia unit downstairs to aid with the stimulation of people and to give more mobile people independent access to outside areas. We had been told about this change at the last inspection although it had not yet been completed and a fixed date had not been confirmed.

•□The registered manager had reduced the number of areas in the service that were in use due to the reduced occupancy of the service and to aid the deployment of staff and management of risks to people.

•□We saw the provider had tried to make improvements such as dementia friendly signage; however, this was not always well thought through. For example; one person had a stair gate across the door to their room due to issues with others wandering in. We saw that next to their room was a dementia friendly sign for

the toilet with an arrow that pointed towards their bedroom door. The provider had failed to identify this issue prior to our intervention although immediate action was taken to rectify this issue.

• We found the temperature within the service to feel high and staff told us this was an ongoing issue. A healthcare professional we spoke with during the inspection commented on the heat and told us this was regularly the case during their visits and may impact on the health and behaviour of people living in the service. We saw the registered manager had fans in use throughout the building although the temperature remained very high.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

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

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

- People who were able to share their views told us they were satisfied with staff. One person told us, "They are good enough to me". Another told us, "Staff care". Relatives told us they had seen improvements and were happy with the staff team. One relative told us, "They are not talking in corners as they were before". Another told us, "I have got no bad words for the staff. They are caring people. It is a management issue".
- Staff had not fully considered the impact of the behaviour of others on people's wellbeing in their own homes. One person told us, "It's not nice that a woman swears like that". A relative told us, "[Person's name has gotten used to the noise, the shouting out. [They'll] say, 'he's crazy' or 'she's crazy'". A third said, "The other residents get into arguments and the staff come to intervene". Care plans did not consider the impact on others of any distressed or challenging behaviours.
- We found staff to be dismissive of distressed behaviours during the inspection as 'just a person's personality'. They did not proactively try to reduce the distress of these people which impacted on the individual's wellbeing in addition to that of other people living with them.
- We saw some examples of positive interactions between staff and people during the inspection, but we also saw examples of negative interactions. For example, we saw one staff member supporting someone to eat in a kind, gentle and supportive way. They sat with them at eye level and spoke with them, giving them reassurance and responding to their cues. By contrast we saw staff not responding to people expressing a need for the toilet and supporting them to eat while standing over them. Staff were not consistently supporting people in a caring way.

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

- People who had capacity to share their views told us they were involved in decision making about their care. One person told us, "I get up early, I like to be out of bed early like I am used to". Another person told us, "If I ask for anything I always get it, can't say anything about it, look after me well".
- Where people lacked capacity, we found there were inconsistencies around how well people were supported to make choices. Relatives gave us mixed views, some told us they were involved appropriately, and others said they were not. One relative said, "Unless you ask you don't get told" and "There's no [communication] between the family and staff".
- We saw inconsistencies across the care delivered and some improvements were not embedded successfully. For example, the new registered manager had introduced a system where people were shown meal options plated up to assist them with choices. This is known as good practice to help people, in particular with dementia or cognitive impairment, make an informed choice. Staff implementing this practice showed people plates of food but did not explain what they were and simply asked which a person

wanted. This was not an effective way to deliver this good practice approach.

Respecting and promoting people's privacy, dignity and independence

- People who were able to share their views told us staff supported them in a dignified way and helped with their independence. One person told us, "[Staff] are sensitive with all the things they do". Another person told us, "Staff knock the door. I've never felt embarrassed by staff". A third said, "After dinner [staff] help me try and walk".
- Relatives mostly supported this view. One relative told us how cleaning staff respected their family member's privacy and personal space. They asked the person for their room key before they cleaned and would lock up and give the key back to them. Another relative told us, "Absolutely [staff] treat her with dignity and respect".
- Other relatives told us they felt people's dignity wasn't always upheld due to failings in ensuring personal care was completed regularly. We saw this demonstrated from personal care records and saw that people did not always have tasks completed, including oral care.
- We saw some good examples of people being treated with respect and dignity, yet this practice was not consistent across the staff team We also saw examples of where people were not treated with respect; for example, not being addressed with their preferred name.

Requires Improvement

Is the service responsive?

Our findings

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

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

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

- At the last inspection we found the provider was not meeting legal requirements around the provision of person-centred care. At this inspection we found the provider had failed to make sufficient improvements to ensure they were meeting the requirements of the law.
- People and their representatives were not always fully involved in developing care plans. One relative told us they had been telephoned about a review of the care plan, but they had not been told it was happening. They told us, "They rang me about it on the day. I knew nothing about it". Other relatives told us they had been involved. We found letters had been sent to relatives requesting their involvement in care plans and reviews although these did not demonstrate that times and dates were convenient to the representatives involved. The registered manager told us how they were looking to involve relatives more in care planning moving forwards.
- Care provided was not yet effective despite the new registered manager commencing improvements in care planning processes. Care delivered was also not yet person-centered and it was not always in line with care plans and risk assessments. We saw multiple examples of where people were expressing a need for support that was not recognised by staff such as shouting out or requesting the toilet.
- We found people's needs in relation to distressed or challenging behaviour was not yet fully understood, and care was not always effective. Staff did not understand how to identify triggers for behaviour and how to use this information to proactive manage people's needs and reduce risks to others.
- We found people's historic preferences were not always understood. Staff we spoke with were not always able to describe some people's personal histories and backgrounds. As a result, people's preferences in relation to details such as how they spent their time or what clothing they preferred were not always fully understood. One relative told us, "[Person's name] always worn a shirt and tie and would be nice to see him in this occasionally".
- Relatives told us some people's needs in relation to personal care were not being met. One relative told us, "[Person's name] hasn't had a shower for over a week". We found personal care records did indicate people were not always having frequent baths or showers. Records also showed that people were not always having regular care such as oral care. Another relative told us their family member was getting distressed as they wore a pad rather than being assisted to go to the toilet. Staff we spoke with confirmed they were still continent and able to use the toilet and could not offer an explanation around the current arrangements. The person's care plan also was not reflective of their abilities and needs. It also did not include a rationale as to why their preferences around their continence were not being met.

The provider's failure to ensure that people's needs were understood, documented in care plans and effectively met was a continuing breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014 Person-centred care.

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

•□People who were able to share their views told us there was insufficient things for them to do. One person told us, "There's not a lot to do". Some relatives told us there was recently more one to one interaction with people, but most told us there was insufficient opportunities for people to be engaged in meaningful activities. One relative told us, "There aren't a lot of activities in the lounge". Another told us, "There is nothing for anybody to do. They are fed, watered but are left to their own devices". A third said, "That [staff member dancing with people] has never happened before. I think it's because you are here". Another said, "Staff are more involved [with people], but today [during the inspection] the staff have tended to be more interactive than normal".

•□We saw activities coordinators were in post and we observed some high-quality interactions with people. We found they had begun to organise some positive activities such as a trip to a local museum which was highly enjoyed, and a summer fete was taking place shortly following the inspection. However, we found the activities coordinators were often required to support staff with care which removed them from their role.

•□We saw care plans around activities and leisure did not consistently contain detailed information about people's individual preferences around how they wanted to spend their time. We saw records of activities completed were poor and demonstrated days were people were engaged in no meaningful activities. Records also demonstrated a lack of understanding around what a meaningful activity was; for example, some activities were logged as a 'chit chat' where someone had simply asked the person how they were. There was no other interaction recorded with these people on that day.

•□We saw that scheduled activities plans were in place but were not followed during the inspection. For example; in one part of the service a coffee morning should have taken place during the first day of our inspection. This did not happen, and a staff member told us it had not 'taken off' and that it was difficult for them to make the coffee and get people together.

The provider's failure to ensure that people's individual needs and preferences around meaningful activities were known and understood was a continuing breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person-centred care.

End of life care and support

•□We found people's care documents contained a care plan for use at their end of life. We found the care plans used were a generic template while some details had been personalised they did not contain detailed information about people's personal wishes.

The provider's failure to ensure that people's individual wishes at the end of their lives had been considered and planned for was a continuing breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person-centred care.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

•□We found the registered manager had made some improvements to communication systems. For example, we saw that steps had been taken in collaboration with family members to create a communication book and 'basic phrase' list for someone who did not communication in English as their first

language.
•□We found further improvements were needed within the service. Systems such as picture cards or other communication systems were not being used to help people understand information given to them. We found while important policies such as the complaints policy had been developed in an 'easy read' format, they were not freely available to people in this more accessible format and people were not aware of this.

Improving care quality in response to complaints or concerns
•□People were not able to share their views around the management of complaints. Relatives gave us mixed views around the response they received. One relative told us, "The nurse attacks the problem straight away". Another relative told us how they regularly raised concerns with staff but did not always feel they were adequately addressed. These concerns had not been captured in central complaints records.
•□We looked at complaints records and saw the registered manager was keeping a record of formal complaints made. They completed investigations and ensured a written response was sent to complainants.
•□We found improvements could be made to ensure complaints raised with staff were reported to the registered manager to ensure the oversight of complaints was accurate. This would help the registered manager understand issues and concerns within the service and drive improvements.

Inadequate

Is the service well-led?

Our findings

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

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- At the last inspection completed we found the providers governance and quality assurance systems were inadequate. As a result, they were not meeting the requirements of the law. At this inspection we found the provider had failed to make sufficient improvement and remained in breach of the law.
- A new manager had been appointed and was registered with CQC on 19 July 2019, five days prior to the inspection. Relatives told us they felt this registered manager had made improvements. One relative told us, "This one [manager] seems to have kick started something". Another told us, "The manager is much better". A third told us they had seen the registered manager doing visual quality checks in the service. They told us, "The care manager was doing observations last week".
- We found the registered manager was making improvements in the service. However, the provider had failed to ensure sufficient improvement had been made overall. Significant levels of risk remained present in the service that the provider had failed to ensure were identified and addressed.
- While people we spoke with were not able to share their views around the details of improvements made in the service overall, they did tell us the skills of the staff team were inconsistent. People and their relatives shared views around numerous improvements that were still required.
- The provider had failed to ensure effective reporting systems were in place. As a result, the registered manager was not aware of specific incidents that were arising within the service, including incidents involving behaviours that can challenge. This meant risks were not fully understood and plans were not put in place to manage these risks.
- The provider had failed to ensure that systems around the safe management of medicines were effective. We identified that auditing systems were not including errors that we identified during our inspection. We found issues with the administration of sedating medicines; including medicines prescribed on an 'as required' basis being administered without any evidence of need. We also found further concerns including protocols to outline when 'as required' medicines should be administered were not always in place or contained insufficient guidelines for staff. The provider had failed to capture these errors as part of their internal quality checks. As a result, people were exposed to the risk of avoidable harm.
- We found further issues with the providers quality assurance and auditing systems, including a failure to identify where records were not accurate or updated, issues with the application of the MCA, concerns in person-centred care, risk management, safeguarding and staff deployment.
- The provider's most recent action plan submitted to CQC prior to this inspection highlighted that the provider was not aware of the concerns we found, and they felt significant improvements had been made. We found insufficient improvement and quality assurance.

The provider's failure to ensure effective governance systems were in place was a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance.

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

- We found the registered manager was ensuring that open and transparent contact was made with relatives where they were aware of incidents and concerns; including safeguarding incidents, injuries and skin damage.
- The registered manager was open and honest during the inspection, they were receptive to feedback and demonstrated a clear desire to drive improvements within the service.
- We found representatives from the provider during the inspection to be less receptive to feedback that questioned the current standards of quality within the service.

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

- People were not able to share views around their involvement in the service. Relatives told us they would like to be more involved but did not feel engaged. One relative told us they would like to be involved in assisting with trips out of the service but did not know how. Another relative said, "I shout my opinions at [staff member's name]; they give me the forms to fill in. [Staff member's name] wants opinions but they are not here enough. I think [they are] a bank nurse and has outside interests". Some relatives told us they attended family meetings, but others told us they 'didn't bother' as they did not feel engaged.
- Some relatives told us they had not received requests for feedback about the service and had not received things such as a quality survey seeking their views. However, we did see records of a recent survey completed in June 2019. People asked for more trips, garden time and redecoration in addition to staff engagement. The registered manager had begun to address these requests by taking action such as arranging trips, applying to the provider for refurbishment funding and improving the use of the garden.
- We found there was insufficient involvement of people and relatives at the time of the inspection. The registered manager was able to describe how they were making plans to get people more involved in the development of the servicing moving forward. We will check this has been done at our next inspection.
- Staff told us they felt the new registered manager was effective and was making positive changes within the service. One staff member told us, "I was at a point where I didn't' want to come to work but [registered manager's name] is great. They also told us, "If you've got ideas you can share them".

Working in partnership with others

- Healthcare professionals visiting the service told us they felt relationships with the staff team were positive. We saw that staff were building relationships with external organisations including healthcare professionals. However, further work was to be done in this area to ensure contact was proactive and to ensure professionals had full and accurate information.
- We saw that activities coordinators had begun to take people out into the community, although there were further improvements to be made in relation to fully engaging with the local community.

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

- People were not able to share their views about the culture within the service. Relatives told us they felt the provider had failed to ensure there was stability in management. One relative told us, "There's no consistency. There have been so many managers". Relatives told us they felt the new manager was making a positive impact on the culture and care provision in the service. One relative told us, "This manager is the

best one we've had". Another relative said, "The difference is incredible. If I could have moved [person's name] six months ago I would have… [The registered manager]'s attitude means that the staff are so much happier, that comes across now. They told us, "It was more task orientated, that doesn't seem to be the case now".

• Staff told us the new registered manager had made a huge impact on the working environment within the service. One staff member told us, "The staff morale is great. Even the ones that used to moan don't any longer. She has lifted our spirits". Another staff member said, "The impact [of the new registered manager] has been fantastic. It's the first time I have seen person-centred care".

• We found the registered manager to be open during the inspection. They were keen to continue to identify issues and to make improvements. We found that representatives from the provider were not as open and transparent when discussing the concerns and issues within the service.