Ravine Ltd

Belle Vue Court

Inspection report

680 Woodborough Road
Nottingham
Nottinghamshire
NG3 5FS

Tel: 01156484419
Website: www.belle-vue-court.com

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

Summary of findings

Overall summary

About the service
Belle Vue Court is a residential care home providing accommodation and personal care to up to 51 people. The three storey premises are divided into a north and south wing. At the time of our inspection there were 16 people living at the service including people living with dementia.

People's experience of using this service and what we found
People were not protected from the risk of harm or abuse. Not all staff knew how to report or who to report safeguarding incidents too, lessons were not learnt which resulted in incidents being repeated. Safe recruitment practices were not always followed.

Medicines were not managed safely, and people did not always receive their prescribed medicines on time. Risks associated with people's healthcare needs had not always been assessed and risk reduction measures were either not in place or not followed. People were at risk of infection due to poor infection control practices. Premises and equipment were not clean or hygienic and staff were not clear on their responsibilities.

People did not always receive personalised care and people's care plans did not always contain relevant up to date information. People were referred to external professionals, but recommendations were not recorded or acted upon.

People were not engaged or offered the opportunity to participate in activities. The home was poorly decorated with empty bookshelves and lacked items of stimulation or interactions.

People and their relatives told us they were not included in care planning and that their complaints and concerns had not been acknowledge or responded to. Most relatives we spoke with were not aware of who the registered manager was.

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

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
This service was registered with us on 31 January 2022 and this is the first inspection.

Why we inspected
The inspection was prompted in part due to concerns received about staffing levels and medicine management. A decision was made for us to inspect and examine those risks.

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 person centred care, staffing, safe care and treatment, safeguarding, consent to care, meeting nutritional and hydration needs, dignity and respect and governance and leadership at this inspection.

Please see the action we have told the provider to take at the end of this report.

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
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our safe responsive below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Belle Vue Court

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 Health and Social Care Act 2008.

As part of this inspection, we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by 2 inspectors, a specialist nurse 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.

Service and service type
Belle Vue Court is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Belle Vue Court is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection

This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since becoming registered. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 5 people and 10 relatives of people who used the service about their experience of the care provided. We spoke with 6 members of staff including the registered manager, operations manager, care assistants, domestic staff and kitchen staff. We also spoke with 3 professionals who worked with the provider. We reviewed a range of records. This included 5 people's care records and multiple medication records. We looked at 3 staff files in relation to recruitment and multiple agency staff profiles. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Inadequate

Is the service safe?

Our findings

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

This is the first inspection of this newly registered service. This key question has been rated 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 were not protected from the risk of abuse, harm or neglect. The registered manager had failed to notify the CQC and local authority of safeguarding incidents in a timely manner. A staff member told us they had identified this in the registered manager absence and corrected the error. This placed people at continued risk of harm or abuse.
- The provider had failed to meet their safeguarding policy which stated 'All employees will complete the "understanding abuse" workbook as part of the care certificate. The operations manager confirmed that staff do not currently undertake the care certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.
- We reviewed on persons care plan and daily notes which showed that over a period of 1 week the person displayed behaviour of frustration that resulted in physical aggression towards people and staff on 10 separate occasions. Staff had not completed incident forms or reported incidents to a manager. This meant we could not ensure staff knew how to recognise abuse or how to record and report it.
- People told us they felt some staff were "cold and unprofessional" toward them and were often left without their call bell so they could not call for help when needed. Our observations supported this, as during our inspection one person was found to be in their room with the call bell out of reach.
- The local authority made recommendations to improve the quality of care following audits and safeguarding referrals they had received to reduce the risk of re-occurrence. The provider had not successfully implemented the recommendations, systems or processes as issues remained and were observed on our inspection. This meant people remained at risk of receiving abuse, harm and neglect.

The provider failed to ensure that people were protected from abuse and improper treatment. This was a breach of Regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Assessing risk, safety monitoring and management

- People were not protected from risks associated with their needs and risks associated with falls prevention were poorly managed. We observed a sensor mat placed underneath a person's bed. The equipment was dirty and stuck to the floor showing it had been in that position for large period of time. This was raised with the operations manager on inspection who took immediate action. However, this placed the person at increased risk of injury from falls.
- The provider stated all baths had thermostatic mixer valves fitted (TMV) to reduce the risk of scalding. On inspection the water was tested in a bath and the water was found to be 60 degrees. This posed a scalding risk to people who had access to this bathroom and the bath was found not to have a TMV fitted.

● The provider used a sensor system that detected when a person may be mobile and be at risk of falls. Staff we spoke with stated they were not knowledgeable about the system and its use. "One staff member said, "I don't turn the system on most of the time, it's very sensitive and goes off if a pin drops and if I don't respond to each incident I get told off, so it's easier just not to switch it on." This placed people at risk of avoidable harm from unwitnessed falls.
● One person's care plan stated they required a staff member with them for 18 hours each day, but they were only receiving 12 hours of this one to one support daily. When we spoke with the registered manager, they confirmed the care hours had been reduced in part because of improvement to the person's condition but also as a result of issues in recruiting staff. There was no evidence in the care plan that a formal review had assessed the risk associated with this reduction in hours. This meant other people living at the home were not protected from the risks these behaviours.
● Risks associated with eating and drinking were not always effectively managed. We found drinks thickener was stored in a kitchen cupboard that all people had access to, and the room was not temperature controlled. This was not in line with best practice or the providers policy which states thickener must be stored 'out of reach' and at the 'correct temperature' to reduce the risk of choking.

Using medicines safely
● People did not receive their medicines in a safe or timely manner. Staff did not have access to all the information and paperwork they needed in order to support people with their medicines safely.
● One person told us, "I do not think I am getting good care, staff are supposed to wake me at 7.15am for medicines before my breakfast but they don't, it's dinner time now and I still haven't had them." We reviewed care plans of 2 people who required timed medicines and identified multiple occasions where people had not received their medicine as prescribed. This placed people at risk of requiring extra care or consequences affecting their quality of life.
● One person was prescribed medicine 'as required'. No instructions or guidance could be found to support staff with administering this medicine. Records completed did not justify why the medicine had been given and where entries had been made best practice had not been followed as records were over written. This placed people at risk of receiving medicines which were not needed.
● During the inspection it was identified that a staff member had administered medicines and recorded the action electronically using another staff member's log in. This was raised with the operations manager who took immediate action. However, this action posed a risk of records being falsified and people receiving inaccurate medicines.
● One person received their medicines covertly. There were no records to show this had been administered since the electronic system had been in use. The matron took action immediately to rectify the situation however we could not be assured this person had received their medicine as prescribed which placed them at risk of harm.

Learning lessons when things go wrong
● Lesson were not learnt when errors or incidents had been identified and recorded. This resulted in errors being consistently repeated. People were at ongoing risk of being over or under prescribed their medicines.
● Audits had failed to identify that a person's prescribed controlled drug had been witnessed as administered by a staff member who was not assessed as competent on multiple occasions. This placed the person at risk of harm from receiving their medicine in an unsafe manner.
● The registered manager told us that medicine administration records were audited daily. However, the registered manager acknowledged they had not completed the training for the electronic system now in use. This meant the registered manager did not have oversight of the issues we identified, and this placed people at risk of significant repeated harm.

Preventing and controlling infection

● People were at risk of infection due to poor infection prevention and control practices.

● Best practice guidance was not consistently followed to help reduced the risk infection. For example, we observed several staff wearing personal protective equipment (PPE) incorrectly and not using aprons when serving meals.

● Staff wore jewellery whilst delivering care, this included rings, bracelets, watches and earrings this increased risk of infection control and cross contamination.

● The home was visibly dirty. For example, areas such as kitchenettes and dining rooms were visibly dirty. There were faeces and dirt found in bedrooms and bathrooms on multiple floors of the home.

● Staff told us they did not have enough time to incorporate cleaning duties alongside care tasks in communal areas. Clarification was sought from the register manager; however, they were not aware of the hygiene issues we identified.

● Good food hygiene practice was not being followed in communal kitchenettes. We observed uncovered and unlabelled food stored in cupboards. This placed people's health at risk.

The provider failed to ensure that medicines were administered safely and failed to ensure correct procedures to prevent and control the risk of infection were implemented and followed. Assessing risk, safety monitoring and management were not managed safely. This was a breach of regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

● There were no restrictions on people welcoming visitors to their home and the provider was following currently published visiting guidance by the Department of Health and Social Care.

Staffing and recruitment

● Unsafe deployment of staff across the home meant people were at an increased risk of not having their needs met. Staff were not always recruited safely. Comprehensive work histories were not obtained. This meant the provider could not ensure the staff recruited had the relevant experience or skills to work with people with complex needs.

● There was a lack of consistency of staff and they were not always provided with the information relating to people's needs. For example, we spoke with an agency care assistant who was working alone supporting 4 people on a unit of the home. The staff member was only aware of 3 people. "I haven't worked on this unit before, so I don't know the people no one told me there were 4 people and the senior is not here." This meant people were at risk of receiving care from staff who were unaware of their needs.

● Relatives told us there not enough staff, one said, "Morale is very low with the staff; they do their very best. They take turns to be cleaners, cooks, carers, receptionist". Another relative said, "There are just so many agency staff, they don't know my [relative]. I asked for a juice as [name] was thirsty, they brought a full glass of neat cordial. I'm concerned, what would have happened if I had not been there."

Inadequate

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.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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

- People's needs and choices were not consistently assessed in line with current legislation and guidance in a way that helped to prevent discrimination. For example, one person's summary care plan information did not show the primary condition they were living with. This did not support staff to fully understand people's needs.
- One person's care plan detailed how they could become anxious and show signs of distress. The care plan detailed intervention methods staff should take and directed them to review the person's "Positive Behaviour Plan". However, we found no evidence of this section of the care plan. This meant care plans were not holistic and had not included a functional assessment of behaviours, which was not in line with best practice.
- The provider had not assessed and considered the longer-term aspirations, goals and outcomes of each person. People's support plans had not set out pathways to future goals, for example teaching people new skills to promote and enhance their independence. The provider had not collected any data about how people were progressing or struggling, with their hobbies, interests or daily living achievements.
- People's social needs were not assessed, and the provider did not deliver care in ways that met people's individual needs. People were not supported to take part in activities they enjoyed doing or found meaningful.

Due to a failure to consistently assess and deliver person centred care, people were at risk of discrimination. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- Not all staff received an induction into the service. This placed people at risk of harm. Some agency staff working at the home during our inspection visits, did not receive an induction. Agency staff were observed supporting people with nutrition needs. However, when speaking with staff they were unaware of the person's name or nutritional needs. This placed people at risk of receiving inappropriate nutrition.
- Permanent staff did receive an induction, training and were aware of people needs. However, we observed staff members swapping their assigned roles with each other without informing management. This was not identified on the registered managers walk round and placed people at risk of receiving ineffective care.
- One person required one to one support by staff members who had been trained in supporting the person's mental health needs. Daily notes confirmed that agency staff had supported this person for large periods of time and did not have the required training. This placed the person at risk of harm and

inappropriate restraint as staff had not received the appropriate training in physical restraint.
● Staff told us they did not receive regular supervisions. Audit reports showed some staff had received a supervision within the last 12 months, however 7 staff members were not recorded as having a supervision. This limited opportunities for feedback and discussions on improvements and developments.
● We observed best practice and guidance not being followed, and staff did not always work competently. Although training had been received, we found staff did not always follow safe infection prevention control guidance and incidents involving behaviours linked to people's health conditions were not recorded or reported. This placed people at risk of harm from infection and actions from behaviours of people living at the home.

Failure to ensure staff were competent to provide safe and effective care was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● People were not supported safely or effectively to eat and drink a balanced diet. Staff recorded the amount of drinks people were offered and how much they had drunk during the day, but no follow up action was recorded to state whether people had obtained their requirements .
● For example, one person's nutritional care plan stated they needed to be offered drinks on an hourly basis to ensure their daily minimal intake was reached. The daily notes showed a period of 26 hours where no drinks were offered or received and staff had not identified or reported this to management This placed the person at risk of dehydration and complications from their health condition.
● Staff told us there was no access to the kitchen or food once the chef had left. One said, "If someone is hungry in the evening we have to nip to the shop and buy them treats as the kitchen is now locked." This was discussed with the clinical lead who took action to address the concerns staff had raised.
● Compliance checks for nutrition had not been reviewed by the registered manager for 3 months despite 4 people being identified as medium risk and one person as high risk. This placed people at risk of receiving an inappropriate nutritional diet.

Failure to ensure people had their nutritional and hydration care needs met was a breach of regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 MCA 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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

●The provider was not working within the principles of the MCA. Staff received training in mental capacity, however the provider had not ensured staff understood the principles of the MCA, including how to support people to make their own decisions, and how to proceed if the person lacked capacity for a particular decision.
● Mental capacity assessments did not document the views of people or relatives. For example, one person's consent to care form had been sign by a staff member. We spoke with the staff member involved who confirmed the person had not been asked for their consent. This meant there was a risk people's rights under the MCA would not be upheld.
● Care plans we reviewed contained information to people did not have capacity to make an informed decision regarding care. However, a best interest decision had been completed to say people had capacity to agree to CCTV recording. The provider had signed this document on the person's behalf. This contradictory recording meant it was not clear how consent had not been sought and the principles of the MCA had been followed.

People's consent to care and restrictions had not been sought. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The provider had assessed people to see if they were at risk of being deprived of their liberty and had made DoLS applications for a number of people.

Adapting service, design, decoration to meet people's needs
●The provider had not ensured the environment was suitable for people's needs. The service was not designed in a way which made it friendly and accessible to people with dementia.
● There was a lack of clear signs around the building to help people orientate themselves. For example, bedroom doors were a uniform colour and design, which meant people with dementia could have difficulty identifying their own room. Our observations supported this as we observed people wandering in corridors.
● Lack of consideration for the building design and decoration put people at risk of being disoriented. This had the potential to reduce people's independence skills. For example, there was a risk that people could not locate the toilet due to lack of signs they could understand.
● A relative told us, "I've told them this room is not dementia friendly and I have told them there is no colour in the room and [name] needs to have things painted red to make it easier, we had a meeting with the [staff member] and they were going to sort it, but it hasn't happened."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● The provider monitored people's health, care and support needs but did not consistently act on issues identified.
● Care plans contained referrals to other medical professionals and recommendations were received however we could find no evidence that these were acted upon. For example, we reviewed a person's care plan that contained a letter from the GP, but there was no access to the letter and no record of follow up actions.
● The provider employed specialised services internally such as an occupational therapist. This meant that people who required this service were seen in a timely manner.

Inadequate

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.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Respecting and promoting people's privacy, dignity and independence
- People were not always treated with dignity and respect. We observed staff shouting across corridors to each other discussing people personal care needs. This did not respect people's privacy or dignity.
- One person was observed to be wearing multiple incontinence aids. The person stated to us she had requested her continence needs were assessed but no action had been taken. We spoke with the registered manager who advised this would be reviewed as a priority,
- A relative told us, "Staff don't help [name] to be independent, their slippers and glasses went missing a few weeks ago so they couldn't get about independently."
- We noted communal areas and some people's rooms were dirty and untidy. There was food debris and staining on furniture and floors that appeared to have been present for a substantial period. This did not promote people's dignity.
- Communal bathrooms on the ground floor were away from the unit and separated by a door locked with a keypad. This did not promote people's independence with their personal care needs.

Ensuring people are well treated and supported; respecting equality and diversity
- People were not always treated well or with respect. We observed a lack of interaction and engagement. Staff who were supporting people directly with one to one support did not speak or engage in any conversation with the person.
- We observed a person request their wheelchair was used to mobilise to the dining room stating they were tired. The wheelchair could not be found so staff supported the person to walk. This meant the person was not treated well or supported with their request.
- A relative told us they had concerns that their loved one's clothing was not being washed. "I raised it with the registered manager, and they made me feel like I was lying. I take the clothes and sheet home now to wash them." The registered manager acknowledged there had been issues with the laundry but improvements had been made.
- One person living at the home told us, "The place should be closed down, I am going out of my mind living here. I feel like a prisoner in my room and I sometimes don't see staff for 3-4 hours." This was reflected in what other people and relatives told us including, "There's a lack of staff to interact with" and "I know [name] is not happy here."

The provider failed to ensure people were being supported in a caring, dignified and respectful way. This is a breach of regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● We found little evidence that people had been involved in making decisions about their care.

● Relatives told us they did not feel included in their loved one's care. For example, a relative said "I only know [name] has had medical appointments because I get the letters from the hospital. The home never tells me." Another relative said, "I have been asking to see his care plan and medication for at least 6 weeks and still nothing."

● People told us they were involved in decisions about their care and support upon admission to the home. However, there was no evidence people had been involved in developing or reviewing their care plan. This meant people's wishes about how they wanted their care delivered may not have always been known.

Due to a failure to consistently assess and involve people in care planning, people were not receiving person centred care. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated Inadequate. This meant services were not planned or delivered in ways that met people's needs.

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

- People were not always involved in decisions about their care, treatment and support.
- Feedback we received from relatives detailed they had not all been involved in the care planning process. For example, one relative told us, "We were not involved with [name's] care plan. They have told me I would be part of a review but that doesn't seem to have happened."
- Care plans did not contain enough person-centred information to support staff on how to meet people's needs. For example, one care plan summary stated the person was independent with all personal care needs. However, the person required assistance with all aspects of this care. Daily notes showed some staff supported with this but frequently staff did not. This was raised with the registered manager who advised a review would be completed.
- One care plan stated the person required labels on items within their room and a calendar with dates and times of family visits to promote independence. We saw no evidence that this had been implemented.
- One relative described to us how staff had cut their relatives hair without permission, "They informed me that someone had cut [name] hair and they weren't supposed to. They said they were going to investigate, but I never heard anything."

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

- The provider did not always support people to follow their interests or encourage them to take part in social activities relevant to their interests.
- Staff identified that the lack of an activity's coordinator was negatively impacting people. One staff member said, "Some people have said they would love to go out into the community, and I have told management lots of times, but it hasn't happened yet." A person living at the home said, "There are no activities. I like gardening but I don't get taken out into the garden."
- A relative told us, "They said they would provide a TV on the wall for [name], but they have been lapse and it still hasn't happened. Every time I ask, they say it is on order, but 10 months is a long time. That would make such a difference to [name]."
- Another relative said, "They are not doing anything with [name], They are just left to do nothing. [Name] goes for dinner and then back to their room. There are empty bookshelves, there is no stimulation at all, I ask [name] what does all day and [name] says 'I just lie in bed', they are absolutely bored stiff."
- We did not observe any organised activities during the inspection and care plans we reviewed did not contain any evidence that any meaningful activities had taken place.
- Dining tables were not set for mealtimes and people were not encouraged to sit at the table. There was only one option of hot meal offered, a meat or vegetarian alternative. Staff did offer to make an alternative

meal for people who did not like the meal.
● Relatives we spoke with told us they had trouble accessing the building especially during weekends and this impacted the amount of time they could spend with their loved one. One relative said, "Gaining access can be difficult. You have to press the buzzer, we waited 40 minutes once."

The provider failed to ensure that people received personalised care to meet their needs and preferences This was a breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Improving care quality in response to complaints or concerns
● Complaints are not dealt with in an open, transparent, timely and objective way. The provider had a complaints policy in place and people knew how to raise complaints. However, people told us the registered manager failed to respond to complaints they had raised.
● A relative said, "I did put in a complaint a while ago; I want the care to be better for [name] and the other residents. I haven't had a direct response yet." Another commented, "I have sent several emails directly to the registered manager, but I never had a reply."
● We spoke with the registered manager but they were unable to identify a record of complaints they had received directly and acknowledge they did not keep a record of "informal concerns". Where complaints had been logged and escalated to the operations manager these had been acknowledged, recorded and responded to in a timely manner.

The provider failed to ensure complaints were identified and actioned. This was a breach of regulation 16 (Receiving and Acting on Complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.
● People's communication needs were not always considered. Staff were aware of the accessible information standard but did have access to any pictorial and easy read format documentation to support communication.
●Weekly menus were printed and placed on a cupboard door in the dining areas, however menus were in small print and not visible to residents.
● We spoke with the registered manager about accessible information and they advised the provider was in the process of developing the documentation that would be implemented in the near future.

End of life care and support
● There was no one receiving end of life care at the time of our inspection.
● Staff received training in end of life care and were able to describe how to care for someone at this stage of their life.

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.

This is the first inspection for this newly registered service. This key question has been rated 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- There was a lack of effective managerial oversight of risk. The internal quality assurance processes had not been used to monitor the service effectively which resulted in repeated incidents. They had failed to identify and improve shortfalls in care at the service.
- Audits were not effective in driving service improvement. For example, audits failed to identify missing water temperatures checks and had not identified the TMV issue we reported on under safe.
- Audits had failed to identify errors in the stock control of certain medicines. For example, stock control forms showed a mental health medicine to have 79 tablets in stock but there were 101. This meant people were at risk of not having received their prescribed medicine.
- Lack of managerial oversight of care records meant these were not consistent. Care plans did not provide staff with accurate information in order to support people safely. This risk was heightened due to the large number of agency staff in use who had never met many of the people they were caring for before providing support.
- The registered manager was not always aware of their legal requirement to notify CQC of events and incidents which impact people. Records we reviewed evidenced that there had been a delay in reporting a number of safeguarding incidents.
- During a direct monitoring activity (DMA) completed with the registered manager on 9 September 2022 the registered manager stated, "The service has a dedicated activities coordinator." However, on inspection the registered manager confirmed the home had not employed an activities co-ordinator since opening in January 2022. A DMA is direct communication between provider and the CQC to assess information and risk.
- The lack of activities and meaning engagement with people meant people spent large periods of time isolated with little activity or socialisation, this did not promote a positive or person-centred culture.
- The provider had cleaning schedules and audits in place, however these were not effective and not always fully completed meaning risks were not identified. The operations manager acknowledged the shortfall with cleaning processes and advised this was currently under development and would be reviewed as a priority.

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

- The manager acknowledged residents and relative meetings were not held regularly, and there was little engagement with people on a day to day basis
- Professionals who worked with the service felt that staff not did have the time to spend with people to

identify changes in their conditions or follow up appropriately, due partly to a large number of agency staff.
● We saw evidence that relatives had been asked for their feedback via forms when visiting people in the home. However, where concerns or issues had been raised there was no follow up action recorded or acted upon.

Working in partnership with others; Continuous learning and improving care
● The provider was working with the local authority to improve care standards following a quality assurance audit. Actions the provider had stated were complete still existed 2 months later. For example, placing of directional signage and dementia accessible information was stated as completed but the issues remained upon inspection.
● The provider's dependency tool had not been used to effectively to reflect the required number of trained staff to meet people's needs. This had resulted in staff distribution throughout the home becoming inconsistent to people's needs. The registered manager was already aware the issue however the people still received support from untrained agency staff.

The provider failed to ensure the quality, safety and leadership of the service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The lack and delay of investigations following incidents, poor communication, delay in reporting of notifiable incidents and safeguarding concerns indicated the provider was not fully aware of their responsibilities under the duty of candour.
● Relatives told us they were not always informed when things went wrong, and communication was poor. For example, one relative told us, "The service hardly ever phones me, my [name] called me in distress and I tried to call the home back to discuss and the phone just rang and rang. I just had to hope my relative has ok." The registered manager confirmed a new receptionist had been employed and this would aid in people being able to contact the home.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive personalised care and support which left people at risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not consistently treated with dignity and respect. Some staff were very task focussed, with little attempt to engage people in conversations to put them at ease.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured staff understood the principles of the MCA, including how to support people to make their own decisions, and how to proceed if the person lacked capacity for a particular decision. Records of assessments of capacity did not document the views of people or relatives. There was no information about how choices had been presented to people in ways they could understand.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment

	The provider did not ensure there were adequate safeguarding processes and systems in place to safeguard people from the risk of abuse and harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider had not ensured people consistently had access to a balanced diet that met their assessed needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider did identify, record and respond to complaints in an effective or timely manner.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure there was adequate staff with the right skills to meet peoples needs.