Redhouse Nursing Home (UK) Limited

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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

This inspection took place on 13 and 15 November 2018 and was unannounced. This service has been rated 'Requires improvement' overall over the four previous inspections. At our last inspections in May 2017 and September 2017, we identified breaches of the regulations related to safe care and treatment and governance. After the inspection in May 2017, we undertook enforcement action in relation to those breaches, however the provider failed to achieve compliance with the regulations. After the inspection in September 2017, we undertook more significant enforcement action to impose conditions on the provider's registration. This required the provider to submit monthly reports to the Commission, about actions they took to improve the safety and oversight of the service.

At this inspection in November 2018, we found again that the provider had still not made sufficient improvements and has remained in breach of those regulations since May 2017. This has continued to put people at risk of poor and unsafe care. This inspection identified an additional two breaches of the regulations related to person-centred care and the provider's failure to submit notifications to the Commission as required. We have taken further enforcement action in line with our processes, in response to this inspection and we have rated the service 'Inadequate' overall.

Redhouse Nursing Home is a 'care home' with nursing. 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. Redhouse Nursing Home accommodates up to 34 older people in one adapted building.

There was a registered manager who was present during our inspection and had registered in March 2018. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People continued to be at risk of poor and unsafe care as the provider had still failed to provide a consistently safe service. We found various examples of how people's risks were still not effectively assessed, monitored and mitigated. Lessons were not learned to improve the safety of the service and practices at the home put people at increased risk of harm. This amounted to a continued breach of the regulations in relation to safe care and treatment.

People's relatives and friends felt the service was safe. One person told us they felt the service was safe, however this was not consistent feedback because two people told us they did not feel safe. Some improvements had been made to how some people's risks were managed including people's support with medicines and staffing level changes. Recruitment processes had not always been followed as planned to ensure people's safety. The registered manager told us they intended to use an improved audit, and to appoint a new infection control lead to support ongoing improvements and ensure good infection control

practices at the home.

Staff told us they felt supported and spoke positively about the supervision and training provided, however we found continued concerns that staff were not always equipped with the skills and knowledge to meet all people's needs. People could not be confident all of their needs would be effectively monitored and met although we saw some positive examples of how people were supported. People were not supported to have maximum choice and control of their lives and staff did not support all people in the least restrictive ways possible.

We received mixed feedback about the food on offer and people's own choices and preferences were not routinely gathered to help inform menu planning. Although we often found positive practice in these areas, improvements were required to ensure people always received safe and effective support in relation to their dietary and hydration needs and to access healthcare services when needed.

Although we often saw caring interactions from some staff, some people's feedback showed staff did not demonstrate a consistently caring approach. We saw staff were often engaged in other tasks and did not often have opportunity to spend quality time and interact well with people. People were not involved in their care as far as possible and opportunities to gather people's views about their care were missed.

Although we identified some people's positive experiences of the service, we identified a breach of the regulations due to the continued concerns that people did not all receive care in line with their needs and wishes. People's needs and preferences were not effectively gathered and met and this put people at risk of poor care. Improvements were required to how people's care was planned, including end of life care. We found continued concerns around people's poor access to activities. The design of the home including dining arrangements were not always developed around people's needs and preferences. There was a complaints process and complaints had been recorded, logged, and responded to. Other systems such as regular care reviews were not in place however to help capture people's feedback and identify any concerns or complaints they had, for example for some people who told us they did not feel comfortable making a complaint.

We found continued concerns in relation to the governance and leadership of the service. Despite some improvements since our last inspection, sufficient improvements were not made overall and systems and processes still failed to effectively assess, monitor and improve the quality and safety of the service. This put people at risk of poor and unsafe care and amounted to a continued breach of the regulations in relation to governance.

Systems failed to ensure risks to people's health and wellbeing were shared, and that risks were effectively assessed, monitored and mitigated to safely meet all people's needs. People were not given routine opportunities to discuss their care, and where some people had expressed needs and preferences, these were not always met. Incidents and shortfalls in the safety of people's care were not rectified and learned from and this put people at risk of harm.

The overall rating for this is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any

key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action.

Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

You can see what action we told the provider to take at the back of the full version of the report.

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.

People continued to be at risk of poor and unsafe care as the provider had still failed to provide a consistently safe service. We found various examples of how people's risks were not effectively assessed, monitored and mitigated.

Lessons were not learned to improve the safety of the service and practices at the home put people at increased risk of harm.

Most feedback we received suggested people and relatives felt the service was safe, however this was not consistent.

Some improvements had been made to how some people's risks were managed including support with medicines and staffing levels.

Is the service effective?

Requires Improvement

The service was not effective.

People could not be confident all of needs would be effectively monitored and met although we saw some positive examples of how people were supported.

People were not supported to have maximum choice and control of their lives and staff did not support all people in the least restrictive ways possible.

Although we often found positive practice in these areas, improvements were required to ensure people always received safe and effective support in relation to their dietary and hydration needs and to access healthcare services when needed.

We found continued concerns that staff were not always equipped with the skills and knowledge to meet all people's needs although staff told us they felt supported.

Is the service caring?

Requires Improvement

The service was not caring.

Some people's feedback showed staff did not demonstrate a consistently caring approach.

People were not involved in their care as far as possible and opportunities to gather people's views about their care were missed.

We often saw caring interactions from some staff, however this was not consistent. Staff were not always available to spend time and interact well with people.

Is the service responsive?

Requires Improvement

The service was not responsive.

People did not all receive care in line with their needs and wishes. People's needs and preferences were not effectively gathered and met and this put people at risk of poor care.

Improvements were required to how people's care was planned, including end of life care and the design of the home. We found continued concerns around people's poor access to activities.

Complaints received had been responded to, however systems did not help capture all people's feedback and concerns to help improve the service.

Is the service well-led?

Inadequate

The service was not well led.

We found continued concerns in relation to the governance and leadership of the service. Systems and processes still failed to effectively assess, monitor and improve the quality and safety of the service, including people's experiences. Incidents and concerns were not appropriately rectified and learned from.

Systems failed to ensure people's risks were effectively assessed, monitored and mitigated which put people at continued risk of poor and unsafe care.

People were not given routine opportunities to discuss their care, and where some people had expressed needs and preferences, these were not always met.

The provider had failed to notify the Commission of all events and incidents as required.

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Detailed findings

Background to this inspection

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

This inspection took place on 13 and 15 November 2018 and was unannounced. The inspection was conducted by an inspector, an inspection manager, an expert-by-experience and a specialist advisor. 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 nurse with a specialism in dementia care. At the time of our inspection, 31 people were using the service. Five people were on a short stay and 26 people lived at the home longer term.

As part of our inspection planning, we sought feedback from the local authority quality monitoring team and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We referred to other information we held about the service to help inform our inspection planning. This included notifications, which contain information about important events which the provider is required to send us by law. We also reviewed monthly reports submitted by the provider, which they were required to send to us as part of our enforcement action undertaken following the last inspection in September 2017.

During our inspection, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. As part of our inspection, we spoke with eight people living at the home and three people's visiting relatives and friends. We spoke with a domestic staff member, the cook and the activity coordinator, along with eight care and nursing staff members, including an agency care staff member and an agency nurse during our inspection. We spoke with the deputy manager, the registered manager and a director of the service, and four

professionals involved in people's care. We sampled documents related to the quality and safety of the service, including records related to eleven people's care and two staff members' recruitment files chosen at random. We received additional information requested from the registered manager after our inspection.

Inadequate

Is the service safe?

Our findings

At our last inspection in September 2017, we rated this key question, 'Requires improvement' and found the provider continued to be in breach of the regulations related to safe care and treatment. This was because the provider had still failed to take sufficient action to ensure people received safe support, with pressure care, medicines and the use of prescribed thickeners. At this inspection, we found again that various risks were not effectively shared and managed to keep people safe. Leadership and staff had failed to identify and address poor risk management and practices and this put people at continued risk of harm. We have rated this key question, 'Inadequate'.

Despite the serious concerns we raised, and the previous enforcement action we took following our last two inspections, this inspection found the provider had still failed to take sufficient action to ensure the safety of the service. The provider has been in breach of the regulations since May 2017 as a result. This inspection found people were at continued risk of harm due to poor practices and risk management, and the provider's track record of failing to provide good standards of safe care.

Practices at the home to support people with food and drinks put some people at increased risk of harm and failed to ensure people would remain safe and well. Although records showed four people had been assessed as at increased risk of dehydration over several months, this had not been acknowledged by leadership or staff and there were no clear plans in place to help reduce this risk. For example, people identified as at increased risk of dehydration should have had additional care records in place to monitor and manage this risk and this was not done. Conversely, target daily fluid intakes records showed staff had been encouraged to give three out of four of those people less than the normal recommended amounts for adults who were not at risk of dehydration. This put those people at increased risk of harm. Our discussions with the registered manager and staff found no rationale as to why targets encouraged those people to be offered less than the normal amount to drink each day. The registered manager and staff were also unaware that these people were at increased risk of dehydration. The registered manager told us they would seek advice from other healthcare professionals as to how to safely meet those people's needs.

In another example, one person's weight records in July and August 2018 indicated that they had lost four kilograms in one month. The person's weight records showed they had continued to lose weight over the following two months. The provider was not able to produce evidence that this person had been referred to a doctor or dietician due to their weight loss and so we prompted for this to be done. Although this person's weight loss had been recorded, this information had not been used, to refer this person for further healthcare support in a timely way. The person's weight loss had not been shared with kitchen staff so they could prepare meals which could have helped reduce this risk. After our inspection, the provider produced evidence which showed the person had since been reviewed by a dietician and had started to gain weight. We saw other concerns that put this person at risk of harm. On the first day of our inspection, we found this person was given thickened fluids although they no longer required drinks to be prepared this way. We raised this with the registered manager, who was not aware of this change to the person's needs three weeks later. On the second day of our inspection, we saw the person was given thickened fluids again in error by staff. The person's needs in relation to their drinks preparation had not been safely monitored and

met. Adding prescribed thickener to people's drinks can cause further dehydration, this put the person at further risk because their records showed they were already had an increased risk of dehydration. Although we brought these concerns to the attention of leadership and staff, they had failed to learn from this risk and continued to put the person at risk due to poor practices and risk management.

Our inspection found continued concerns that the provider failed to make timely and sustained improvements. This meant people's risks were still poorly managed and people were put at continued risk of harm, despite concerns we had brought to the provider's attention through previous inspection and enforcement activity. Although the provider made appropriate safeguarding referrals for example in relation to incidents where some people had shown behaviours that had challenged, we saw little evidence that the provider ensured events and incidents were learned from to improve the safety of the service. For example, during our previous inspection activity, we found people were put at risk of harm due to poor risk management around people's bedrail use. At this inspection, we found continued concerns that this risk was still not managed effectively to keep people safe. An incident had occurred whereby one person tried to break their bedrails. We found there was no bedrail risk assessment in place for this person, either before, or following this incident. This meant the person's risk of using bedrails had not been appropriately assessed. The incident form we sampled had not been analysed to help prevent future reoccurrences and the registered manager was unaware of this incident. Action had not been taken to ensure this person's safety, and this was a continued area of improvement that the provider had still failed to effectively address over our last two inspections. The registered manager demonstrated poor understanding of how incidents could be learned from and analysed to improve the safety of the service. Although the director developed an incident analysis template during our visit in response to our feedback, the provider had failed to develop robust systems so that all incidents were appropriately investigated and learned from incidents to improve the safety of the service.

Our inspection identified the provider's continued failures to improve how people's risks were managed, and to learn from events to ensure the safety of the service. Our last two inspections had identified concerns around how people were supported to use prescribed thickeners and this inspection found continued poor practice which put people at risk of harm. On the first day of our inspection, we saw that prescribed thickener containers were left accessible to people in communal areas and their bedrooms. The registered manager agreed this was a potentially fatal hazard and told us this would be addressed, however we saw those concerns again throughout the second day of our inspection. During our inspection, we also saw some people's fluids were prepared using thickener from the same unlabelled container. This put people at risk of not having their drinks prepared as prescribed to reduce their risk of choking. Although the registered manager agreed that this put people at risk, and told us this safety concern had previously been brought to their attention by the local authority, they had still failed to rectify this. Action was not taken to prevent people being placed at further risk of harm.

The provider had not taken sufficient action to meet their repeated breach of regulation in relation to safe care and treatment. Failure to ensure care and treatment is provided in safe way for service users is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives described the home as warm and clean, as we also observed. Domestic staff were employed to help keep the home clean, and a healthcare professional confirmed, "The home's always clean, there are no odours." However, systems were not always robust to ensure good infection control practices. Although current good guidelines were displayed, we observed that staff did not follow safe practices for example to always use protective personal equipment (PPE) when supporting people. The local authority helped monitor infection control at the home and had informed the provider that further improvements were required. The registered manager told us the infection control staff champion had recently left and

they were looking to appoint another staff member to promote good practice at the home. The registered manager told us they intended to use an improved audit, and to appoint a new infection control lead to support ongoing improvements and ensure good infection control practices at the home. A maintenance book we sampled showed repairs were attended to promptly and routine health and safety checks were carried out. Although staff told us regular fire drills were carried out, the registered manager confirmed that people's personal evacuation emergency plans had not been kept updated and accessible in the event of an emergency.

Recruitment processes were not always carried out safely and as planned to help protect people. Staff told us they had undergone necessary recruitment checks before starting in their roles. This included the provider obtaining character references and completing checks through the Disclosure and Barring Service (DBS). Our sample of staff files at random found one staff member's recruitment processes had been completed safely, however another staff member had started in their role before their DBS check was complete. We found this staff member's DBS check was completed six weeks after their start date and there was no evidence that the staff member had worked under supervision during this period. The provider's processes had not always been followed to reduce the risk of people being supported by staff who were unsuitable.

Although relatives and staff told us the service was safe, we received mixed feedback which suggested people did not always feel safe. For example, one person told us, "It's wonderful here, I'm so very happy," however another person commented, "I don't always feel safe. I tell the staff and they say there's nothing to worry about." We found this person was dissatisfied with aspects of their care and this had not been effectively addressed.

People and staff told us there were enough staff to safely meet people's needs. One person commented, "Enough staff are here". A staff member commented, "I feel there are enough staff as there is always someone to support us. Most agency staff are regulars." We saw staff could respond in a timely way when people asked for help. The registered manager told us they had changed staffing levels and arrangements, which had helped reduce people's falls risks. Systems were in place to ensure people were supported by sufficient numbers of staff.

We saw some people's risks were managed more safely. For example, sensor equipment was used to help manage one person's risk of falls. We saw staff promptly responded to support the person when they wanted to walk, and staff used this as an opportunity to engage well with the person and promote the person's safety and independence. Some improvements had been made to how people's medicines were managed since our last inspection. One person told us they had pain relief when needed. The registered manager told us recent improvements to medicines storage had helped reduce the risk of medicines errors. Staff were aware when people required time-specific medicines to help manage healthcare conditions. Records we sampled were completed appropriately and correlated with people's medicines stock levels. A healthcare professional told us they were regularly asked to review people's medicines to ensure medicines remained effective and beneficial to people. Improvements had been made to how people were supported with their medicines.

Requires Improvement

Is the service effective?

Our findings

At our last comprehensive inspection in May 2017, we rated this key question, 'Requires improvement'. This was because staff were not always equipped with the skills and knowledge to meet all people's needs and people were not always supported in line with the requirements of the Mental Capacity Act (2005). At this inspection, we found continued concerns in those areas and a breach of the regulations because people were still not supported to have maximum choice and control of their lives. We also found people's needs were not effectively met around support with meals and drinks. We have rated this key question, 'Requires improvement' again.

People could not be confident their needs would always be effectively monitored and managed. We found care plans were not in place in relation to some people's known diagnosed health care conditions, mental health needs and risks identified through incidents that had occurred at the service. For example, one person had two specific healthcare conditions however there was no care plan in place to help monitor their needs related to either condition. This meant important aspects of the person's needs were not monitored to help fully understand and safely meet the person's needs.
Staff had also not received specific training including related to dementia to help ensure people's needs could always be effectively monitored and met. We found that the needs of people living with dementia were not fully considered in care planning including communication support and access to activities. The care plan of one person living with dementia stated they could not communicate well, however there was no guidance about how the person could be supported to express their needs with some assistance, for example the use of communication tools or aids. Staff did not always show understanding of the needs of some people living with dementia. For example, one staff member became impatient when one person did not understand what they had said. The staff member told the person, "That's why I was putting [the meal] on your lap for you to try." When another person was confused and asked staff questions, staff failed to engage with and reassure the person appropriately and did not show consideration of the person's perspective of what was happening. The person continued to call out and ask questions but was not responded to as staff were busy. Our discussions with the registered manager confirmed people's dementia care needs were not acknowledged and met as far as possible. We asked the registered manager why care plans had not been developed to help assess and meet the needs of people living with dementia and they replied, "They don't have care plan as such because the home is not EMI [a specialist home for people living with dementia]." This failed to acknowledge people's individual support needs. Staff had received dementia awareness training however systems and guidance in place failed to ensure people's individual needs were always met and understood.

The registered manager told us staff had received more training related to pressure care since concerns we identified at the last inspection. We saw improvements to how people's needs were monitored and managed in this area, and a healthcare professional told us staff sought additional support when needed. Staff had also completed the provider's mandatory training in areas such as Emergency First Aid, food hygiene, and moving and handling. The provider had also arranged training from external agencies in relation to end of life care, the Mental Capacity Act (2005) and Communication and Dignity. Staff told us they received supervision and training and felt supported by the registered manager. One staff member told us,

"Everything I've been faced with, I have a clear perspective of what to do because of the training given." We found however that staff did not receive all relevant support and training for their roles. We saw staff were not always guided when they did not support people appropriately. For example, we informed staff that one person's plate guard was positioned incorrectly because they did not realise. Some people's wheelchair brakes were not applied before people received moving and handling support, on one occasion in front of the registered manager. We needed to prompt the registered manager to raise this with staff because they failed to stop this unsafe support as it happened. In another example, a healthcare professional told us the registered manager had not engaged with support offered to them by external teams. They told us this included catheter care training, which would have helped ensure staff knew how to effectively meet people's needs in this area to prevent hospital admissions. This training offer had not been taken. One person told us they had a blocked catheter around a month before the inspection and told us staff could not do anything about it, so the person had to go to hospital. The provider had not enabled staff with the skills and training offered to provide effective support and possibly prevent this person's hospital admission.

We received mixed feedback about the food on offer and found that some people's hydration and dietary needs were not safely met. One person told us, "The food is okay, I get plenty." Another person told us, "The meals are good, we have two choices, and enough to drink." We saw people were given choices of drinks. A staff member told us they knew people's preferences well but still promoted their choices, for example asking if they fancied the same drink as usual. Although the cook told us they had access to information about people's dietary needs, we found the guidance displayed was not always correct and did not highlight all people's dietary needs and risks. For example, information on display stated one person did not have diabetes, although our sample of the person's care records found they did have diabetes. This put the person at risk of not having their meals and drink prepared in ways that would help promote the person's health, and safely manage their diagnosed condition. Records showed, and we saw that there was a designated staff member who monitored people's fluids throughout the day and checked how much people had eaten. Whilst this was positive practice which helped encouraged people to eat and drink well, we raised concerns with the registered manager because some people's increased risks of dehydration had not been reviewed and acted on to ensure they were offered enough to drink. Our discussions with the cook found menus had not been developed with people's input, or since the last manager left. This was a missed opportunity to involve people in their care and ensure people always had access to meals of their preference.

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. Some staff showed good understanding of how to support people to make choices. For example, one staff member was familiar with the MCA, and aware of additional support some people might need to make decisions at different times. However, people were not supported as far as possible to make their own decisions. Although relatives had been involved in best interests decisions on behalf of one person, there was no evidence of a capacity assessment completed for the person and how the person could have possibly been supported to express their own views and choices.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). 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. Systems did not ensure people's rights were always understood and met and some staff lacked knowledge in this area. For example, we brought it the registered manager's attention that

a staff member kept one person's walking frame out of their reach. The staff member told us, "If you leave it with [person], they will want to come with you, so leave it away and they know not to move." This did not promote the person's rights or dignity. In another example, a healthcare professional told us one person was encouraged to go out independently, to promote the person's mental health and wellbeing. However, we saw that the person's requests to go out were not met. The registered manager told us they had reservations about the person's safety to go out alone and that the person needed to be accompanied by staff. No relevant assessments had been carried out to promote a balance of the person's safety and independence. When the person told staff they wanted to go out, the person was told they would have to wait to see if staff were available to accompany them. The person was not able to go out when they wanted to which did not promote the person's wishes, rights and independence as far as possible.

Systems were not clear to ensure staff knew if people had a DoLS authorisation in place and why. DoLS applications had been made for some people living at the home, however there was no system to track those applications and outcomes. Staff and management gave us varying responses as to who had an authorisation in place, and some people's care plans inaccurately stated DoLS authorisations had been granted for them. This meant people's needs and rights could not be fully understood to ensure they received appropriate support.

The provider had failed to act in accordance with the requirements of the Mental Capacity Act (2005) and ensure care and treatment was only provided with consent of relevant persons. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's rooms we saw were homely and pleasantly decorated and one person told us they liked their room. Some people had personalised items including photographs and their own furniture in their bedrooms. Improvements were required however to the design of the home to ensure this always met people's needs. For example, some people expressed they wanted to have a bath. Staff knew one person often refused a shower because they preferred baths. However, we saw the only bath at the home was inaccessible as several pieces of equipment surrounded and prevented safe access to the bath. The provider had failed to address the poor access to the bath through their own checks of the home and in response to people's expressed preferences. In another example, we saw people's containers of prescribed thickener were also stored in communal areas and their own bedrooms. This presented a hazard as some people could have picked up and consumed the thickener with fatal consequences. The registered manager told us they would designate suitable areas to store people's prescribed thickener to ensure people's safety.

We saw some positive interactions between people and staff. One person responded well to a staff member's caring approach as they encouraged the person to sit down. The staff member told us, "If you walk and talk with [the person], they will keep concentrating," and remain safe while walking. We saw a good approach from another staff member who helped reassure and settled another person when they became anxious. Staff told us they often sat and spoke with this person which helped them to remain calm, and staff described other helpful approaches they tried depending on the person's mood. A professional involved in some people's care told us they had no concerns and commented, "In general day to day care, carers are very hands on and provide support for people." We saw however that this approach was not the consistent experience for all people living at the home and in response to all people's known needs and conditions.

Although we found improvements were required to ensure people were always supported to access healthcare services as needed and in a timely way, we also found positive findings in this area. One person told us they could see the doctor when they wanted to. The home was visited by a healthcare professional on a weekly basis as part of an initiative with the local authority. The healthcare professional told us staff

had since become more proactive in doing their own checks when people became unwell and seeking the healthcare professional's support. We saw healthcare professionals visited people during our inspection including regular review meetings of the care of people on short term stay. Records showed further evidence of healthcare input which suggested some people were supported to access further healthcare support when needed.

Requires Improvement

Is the service caring?

Our findings

At our last comprehensive inspection in May 2017, we rated this key question, 'Requires improvement'. This was because staff were not consistently caring towards people and staff had not always been available to spend time and interact meaningfully with people. At this inspection, we saw those issues had not been fully addressed. We have rated this key question, 'Requires improvement' again.

We saw some people were addressed by name, spoken to at eye level and given time to respond by staff. For example, one person was well responded to when they were distressed. We saw the staff member held the person's arm with care and had a kind, reassuring tone. This was not consistent practice however and staff did not always have time to engage with people effectively. Relatives told us staff did not always have time to talk. We saw staff were often polite and responded towards people, but did not always have opportunity to chat and spend additional time with people. One person tried to speak to staff, and we saw staff would often give the person a closed response and move elsewhere as they were busy with tasks.

Some people's feedback showed staff did not demonstrate a consistently caring approach. One person told us, "Some staff are rough," and our further conversation with the person suggested they sometimes felt rushed by staff. Another person told us, "Some are caring, some are not." We asked the registered manager to investigate this feedback for possible areas of improvement within the staff team. Although mealtimes were advertised as protected times to allow people the time and space to enjoy their meals, we saw a nurse administer one person's eye drops in a dining area while other people ate. The nurse did not ask the person, or others eating nearby if they were comfortable with this practice. This did not promote the person's privacy or show consideration for other people's experiences. People were not always treated with care and respect.

People were not involved in their care as far as possible. Since our last inspection, the registered manager told us they introduced, 'Resident of the day' so each person's care needs would be reviewed and key information shared with staff. This was not used as an opportunity however to involve people in their care, and ensure that staff understood what was important to people. The person who was 'resident of the day' during our inspection, was not made aware of this. Our discussions with the person identified things that were important to them, which were unknown to the registered manager. Where some staff were aware of the person's expressed preferences, this information had not been shared and used to help ensure the person's wishes were met. We found that the menus and activity plans in place, had not been updated since the last manager had left. This was a missed opportunity to engage people in the development of the service, and ensure that people had access to meals and activities of their preferences.

We saw kind and caring interactions from some staff who knew and responded to people well. One person told us they had, "Loads of friends," and we saw they looked content and at home. Another person asked staff how much drinks cost and the staff member kindly reassured the person and said, 'You don't need no money it's all free." We saw some people enjoyed the company of visitors who were welcomed by staff. People could have visitors whenever they wanted which helped them maintain social relationships that were important to them.

We saw a caring approach had been promoted at the home although this was not consistent practice. One person's 100th birthday had been celebrated and the registered manager had arranged for the person to receive a letter from the queen. Photographs of people and notes about things people enjoyed had been gathered and displayed to remind staff of people's individuality. Reference had also been made to good practice such as 'The dignity do's' and the common core principles of dignity. Staff had been encouraged to reflect on their practice and had contributed to a Dignity Tree in the lounge area which showed staff written entries about how they helped to promote people's dignity.

Requires Improvement

Is the service responsive?

Our findings

At our last comprehensive inspection in May 2017, we rated this key question, 'Requires improvement'. This was because care was not always responsive to people's needs including their access to activities. At this inspection, we have rated this key question, 'Requires improvement' again and identified a breach of the regulations. This is because we identified continued concerns that people's individual care needs and preferences were not always gathered and met, including around end-of-life care and access to activities.

At our last comprehensive inspection, people and relatives told us people did not have the opportunity to do activities of interest to them. At this inspection we observed similar concerns. Some people sang along to music playing in a communal area and one person told us they enjoyed this. Another person told us there is, "A gym type of thing and a ball, every other week." Some people told us they had been previously involved in painting and puzzles at the home, and we saw jigsaws and games were stored, but we saw no such activities were offered to people during our visits. One person told us, "What you see is what you get," in relation to activities, with reference to the lack of activity we observed during our inspection. People we spoke with who spent time in their rooms told us they had nothing to do.
An activity coordinator had been recruited, however we saw they provided care whilst on shift which meant they could not lead activities. The activity coordinator confirmed, "I help with people's drinks and meals while I'm here, as a little bit of extra help." The activity coordinator told us they were still gathering views and ideas from people about how they wanted to spend their time. We saw they had not made reference to current good practice, and had not received training to help engage people in activities, for example people living with dementia. Another staff member told us they felt people did not have enough access to activities, although they enjoyed spending time with people during quieter periods. A healthcare professional commented, "I find a lot of the time there is no clear activity happening." People could not be confident they would be supported to access activities of interest to them.

People did not all receive care in line with their needs and wishes. One person told us they were not satisfied with their care because of the home's atmosphere and poor access to activities. We shared this feedback with the registered manager with the person's permission. Another person's needs were not considered and effectively met through care planning processes. The person had expressed they wanted to die. Although a staff member told us the person often said this, the person's care plan made no reference to this concern and had not been updated for seven months. Staff did not always show full understanding of their needs, and we saw the person's care plan lacked sufficient guidance around this. One staff member told the person, "Don't shout at me I'm trying my best," when the person asked for help. This did not always show consideration of the person's perspective and possible impact on their wellbeing. In another example, another person had expressed wellbeing concerns to staff and healthcare professionals. This information was unknown to the registered manager and not reflected in the person's care plan. Although the registered manager told us they had identified other concerns around the person's needs, the person's needs had not been reviewed or effectively met to promote good mental health. Care planning processes failed to meet and respond to people's changing needs.

Our discussions with people and staff found people, and relatives where appropriate, were not involved in

care reviews or other regular opportunities to review their care to ensure people's needs and preferences could be met. Current good practice resources had been sourced, including 'This is me', a support tool by the Alzheimer's Society to enable person-centered care for people living with dementia. However, these documents were not always used. Three people's care 'This is me' details were left blank although records showed they had each lived at the home for a number of months. Another person's care records including details of how to promote their independence, healthcare support and how they wanted their care to be provided, were all left blank although they had lived at the home for over a year. The registered manager was not familiar with the Accessible Information Standards and had not ensured those standards were met through care planning. For example, two people's care plans we sampled identified they had communication needs, however there was no guidance as to how either person could be supported to express their views and choices.

We saw examples of where some people's individual needs and preferences were considered. For example, some staff told us they had learned a prayer to support and encourage one person as they prayed, and staff told us the person responded well to this. The registered manager had helped prepare meals for another person in line with their cultural preferences. Improvements were required however to ensure all people's individual preferences were identified and acknowledged. The registered manager told us a monthly church service was led by a local priest. When we asked the registered manager about whether those services accounted for people of different denominations of Christianity, the registered manager commented, "It's just a church service". We found such preferences and wishes in respect of people's end-of-life care had not always been considered as far as possible. A lead nurse could tell us that some people had funeral plans in place, but they did not show consideration of people's spiritual and cultural needs during end-of-life care. People's care plans we sampled did not contain this information. Although it had been recorded in one person's care plan in June 2018 that the person's end-of-life wishes needed to be gathered, we found these discussions had still not yet been approached or recorded to ensure the person's needs were known. The registered manager told us they had sourced Gold Standards Framework guidance to facilitate end-of-life care planning, but they could not find this guidance during our inspection and confirmed it had not been used. Systems were also not effective to ensure all people's individual preferences and choices would be effectively gathered and met.

The design and décor of the home was not always developed around people's needs. Dining arrangements at the home meant some people sat and ate meals from their laps. The height and positioning of some people's chairs meant their eye levels were often beneath the table. Some people had no sight or support of the table to eat their meals. This did not promote people's comfort, dignity or positive mealtime experiences. One person told us, and had told staff, that they preferred to have a bath and they often declined having a shower. The person told us they could not have a bath because there were no baths available at the home. We saw there was a bath available to use, however the room was inappropriately used to store various items of moving and handling equipment which surrounded and prevented safe access to the bath. Reasonable action had not been taken to meet this person's expressed preference and ensure the design of the home was developed around people's needs.

Failure to ensure people's needs and preferences are appropriately assessed and met is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems such as regular care reviews were not in place to help capture people's feedback and identify any concerns or complaints they had. This meant some feedback including compliments may have been missed and was not used to drive improvements to the service. Information about how to complain was on display. One person told us they had not used the complaints process, however they told us, "I say it out right to the person involved." We saw complaints that had been received had been recorded, logged, and responded to.

The registered manager had responded to some 'grumbles' and concerns, and directed people and relatives to the complaints process if they were not satisfied with the response. The registered manager was in the process of responding to a complaint and safeguarding referral made about the home and care of one person at the time of our inspection. Complaints had been responded to however all people's feedback and experiences were not appropriately assessed to identify and address concerns they may have had.

People gave some positive feedback about the service and how they were supported. One person told us they could get up when they pleased and we saw people often responded well to support from staff. Staff often spoke with affection for the people they supported and tried to get to know people well. Some people who had joined the service on short stay had decided to stay longer due to their experiences of the home. A professional involved in arranging people's admissions on short stays confirmed this, and told us relatives always provided good feedback about the home. We saw examples of how some people's needs had been effectively monitored and responded to. For example, our discussions with a lead nurse found some people had joined the home requiring end of life care and people's conditions had since improved, for example, some people had gained weight and were doing well. A nurse told us they continued to monitor people's needs with input and review from healthcare professionals.

Inadequate

Is the service well-led?

Our findings

At our last inspection in September 2017, we rated this key question as 'Requires improvement' and found the provider continued to be in breach of the regulations related to good governance. This was because the provider did not have sufficient oversight of the service to assess, monitor and improve the quality and safety of the service. Systems and processes were not always effective, and this had put people at risk of poor and unsafe care. At this inspection, sufficient improvements had not been made and we found further examples where people's risks had not been identified and effectively managed through the provider's processes. The provider had not taken sufficient action to meet their repeated breach of regulation in relation to governance and we found an additional breach due to the provider's failure to always notify the Commission of events as required by law. We have rated this key question, 'Inadequate'.

The provider has failed to meet their responsibilities to the Commission. This service has been rated 'Requires improvement' overall over the last four inspections. The provider has failed to provide people with a service that meets the standards of a 'Good' rating and to achieve compliance with all regulations. After our last inspection, we required the provider to submit monthly reports detailing action they took to improve the safety and oversight of the service. This inspection found systems and processes were still not effective to ensure the safety and quality of the service. At this inspection, we identified additional concerns that put people at risk of poor and unsafe care which the provider's oversight had failed to identify and address.

Our sample of incidents found the provider had not always notified the Commission of specific events and incidents as required by law, including safeguarding referrals they had been made due to medicines errors and where a person had sustained bruising due to unknown causes.

Failure to notify the Commission of specific events and incidents is a breach of Regulation 18 of the Health and Social Care 2008 (Registration) Regulations 2009. We are deciding our regulatory response to this breach and will issue a supplementary report once this decision is finalised.

Shortfalls in safety were not rectified and learned from and this put people at risk of harm. On the first day of our inspection, we shared our concerns with the registered manager that people's prescribed thickener containers were left accessible to people in communal areas and their bedrooms. This presented a hazard as some people could have picked up and consumed the thickener with fatal consequences. The registered manager told us they recognised this as a potential hazard, however we encountered the same concerns again on the second day of our inspection and brought it to the registered manager's attention on a number of occasions. People remained at risk of this hazard despite continuous feedback to the registered manager of this unsafe practice. In another example, on the first day of our inspection, we saw one person was incorrectly served a drink that had been thickened. The registered manager was unaware this person's needs had recently changed as confirmed at an appointment three weeks' previously. Despite the registered manager's assurances that this was an error that would be rectified, we saw the person was served a thickened drink again by an agency staff member on the second day of our inspection. The agency staff member told us they did not know the person well, and we prompted the lead nurse to act because the

person had been put at risk again. Effective leadership and systems were not in place to keep people safe from risk of harm and to ensure lessons were learned when things went wrong.

Systems failed to ensure risks to people's health and wellbeing were shared, and that risks were effectively assessed, monitored and mitigated to ensure the safety of the service. Although some people's risks had been identified through regular monitoring, this information was not analysed and reviewed to mitigate those risks. For example, our sample of records identified some people were at risk of dehydration. Our discussions with the registered manager and staff found they were unaware that some people were at increased risk of dehydration. Information on display in the kitchen did not specify this and other known risks related to people's specific dietary and hydration needs. In another example, the registered manager told us they had concerns about one person's behaviours following a number of incidents where they had put themselves and others at risk of harm. Our sample of records found those incidents had not been recorded, and there was no reference to such behaviours in the person's care plan. Staff we spoke with had no knowledge of such concerns. We identified that staff were aware of concerns about two other people who lived at the home. It was of concern that the registered manager did not know this information. We saw both people's needs were poorly responded to and the extent of their health and wellbeing needs were not appropriately recorded and reviewed as part of their care. This meant people's risks were not regularly shared and discussed within the staff team to inform effective care that safely met people's needs.

Systems failed to ensure people's needs would always be safely met. The registered manager had their own monthly medicines audit however this had not ensured people's needs were always safely met. We found that one person's drug directives put in place for their end-of-life care, had expired by over three weeks at the time of our inspection. This had not been identified and we therefore needed to prompt the nurse to take immediate action to address this. In another example, we saw that staff added thickener some people's drinks, from the same unlabelled thickener. Our discussions with the registered manager and staff found they did not know who the thickener had been previously prescribed for and they confirmed a pharmacy label had been ripped off the container. This posed the risk of people being served drinks with thickeners that had not been prescribed to them.

The registered manager failed to demonstrate an understanding of how incidents could be learned from to improve the safety of the service. Incidents, including people's falls and unexplained bruising, had not always been investigated and used to assess the safety of the service. In one example, we identified a safeguarding form which stated one person had received the incorrect type of insulin. There was no corresponding incident form completed or any evidence that sufficient analysis and learning had been taken from this incident. A director of the service offered a response of what action might have been taken, yet confirmed they did not know and that this incident had not been robustly investigated. During our inspection, the director devised a sheet they told us they would use moving forward to help assess and investigate incidents. No such audits or oversight was in place at the time of our inspection.

Systems failed to effectively assess, monitor and improve the quality of the service, including the quality of people's experiences. People were not given routine opportunities to discuss their care, and where some people had expressed preferences, these were not always met. Although the provider had introduced, 'Resident of the day' since our last inspection, this was not used as a meaningful tool to identify and meet people's needs. The provider failed to ensure person-centred care was provided, including failures to identify the service's role in responding to the needs of people around mental health and dementia care. Processes related to the Mental Capacity Act (2005) were not always carried out appropriately. For example, the registered manager had not kept track of when DoLS applications that had been made for some people, and why. The provider had failed to ensure records were accurately maintained to reflect where lasting power of attorney had been granted in relation to some people's care. We also found the registered

manager and deputy manager lacked understanding around when DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) decisions might be relevant. A relative told us they had expressed concerns that they had been asked about a DNACPR decision for one person, however they had not since been informed of what had since happened or had been agreed.

Systems and processes failed to effectively assess, monitor and improve the quality and safety of the service. This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since our last inspection, the registered manager had made changes to the layout of the home which had led to a decrease in the number of falls people suffered. We saw the registered manager made some reference to current good practice guidance. Whilst this was progress was positive, sufficient improvements had not been made in a timely way to the quality and safety of the service and in response to our enforcement activity and concerns identified at previous inspections.
The registered manager told us a lot of audits were not in place when they first joined the service, so they had developed some audits to help oversee the quality and safety of the service, including health and safety, infection control and people's oral care. The registered manager told us they regularly met with the provider who asked them how things were going. Although three monthly audits were completed by a director of the service, we found these had also failed to identify and address shortfalls in the safety and quality of the service.

A healthcare professional told us, "The majority of care staff are wonderful, caring, and they get on with each other, there's definitely teamwork. I'm not sure staff are guided correctly all the time." Staff told us they felt supported by the registered manager and we saw the registered manager had followed disciplinary procedures appropriately due to some concerns around staff conduct. The registered manager told us that due to a high turnover in staff, they had struggled to implement effective changes at the service. Agency staff were used and one nurse positively commented, "It's a lovely team to work with, very willing to show you and support you to do work properly. The registered manger is very approachable and will see what they can do to support you."

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	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to act in accordance with the requirements of the Mental Capacity Act (2005) and ensure care and treatment was only provided with consent of relevant persons. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Failure to ensure people's needs and preferences are appropriately assessed and met is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We have served a notice of proposal to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not taken sufficient action to meet their repeated breach of regulation in relation to safe care and treatment. Failure to ensure care and treatment is provided in safe way for service users is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We have served a notice of proposal to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes failed to effectively assess, monitor and improve the quality and safety of the service. This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We have served a notice of proposal to cancel the provider's registration.