Bondcare (London) Limited

Coniston Lodge Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service:
Coniston Lodge Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service provided both nursing and personal care and is registered to care for up to 92 people. At the time of our inspection, 48 people were living at the service. The majority of people were over the age of 65 years and some people were living with the experience of dementia. The service is owned and managed by Bondcare (London) Limited, a private organisation.

People's experience of using this service:
People living at the service sometimes had to wait for care and support, because there were not enough staff deployed to meet their needs. People had to wait for support with personal care and assistance with meals.

Medicines were not always being managed in a safe way, and some people had not received their medicines as prescribed.

People were not always treated with dignity, respect or kindness. We witnessed interactions which were task based and some which caused people distress and discomfort. The staff supporting these people did not demonstrate an understanding of the person's perspective, nor did they offer comfort or reassurance.

People did not always receive personalised care which met their needs or reflected their preferences. There were not enough social activities or ways for people to spend their time.

The provider's systems for identifying and improving the quality of the service were not always operated effectively. Whilst we found improvements in some areas, these were not sufficient. The provider remains in breach of five Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations relating to person centred care, dignity and respect, safe care and treatment, good governance and staffing. The provider has been in breach of four of these Regulations since we first inspected the service in February 2018.

Notwithstanding the above, people using the service, their visitors and staff spoke positively about their experiences. People told us the staff were kind to them and the staff said they enjoyed working there and caring for people.

There had been improvements at the service, including the introduction of an electronic care planning system which allowed the staff to spend less time on paper work and more time with people using the service.

The provider had shown a commitment to making continuous improvements. Senior managers regularly spent time at the service monitoring this and providing support. There had been increased staff supervision and training, in order to enable them to develop the skills they needed to care for people. The provider's representative contacted us after the inspection visit to let us know about more training they were arranging following the feedback of our findings.

The environment was safely maintained and risks to people's safety and wellbeing had been assessed and planned for. The provider had responded appropriately to safeguarding allegations and worked with other professionals to protect people from the risk of abuse or harm.

People's healthcare needs had been identified and plans described how people should be cared for in respect of these. The staff worked closely with other healthcare professionals and made appropriate referrals when people's needs changed.

There had been improvements with the way in which people's nutrition and hydration needs were monitored and met. The care plans associated with these needs had been improved and the staff recorded people's food and fluid intake. These records could be accessed remotely by senior managers, so they could make sure people were receiving enough to eat and drink. The electronic care planning system alerted the staff if people's weight changed or they did not have enough to eat or drink.

The provider had improved the assessment and recording of people's mental capacity. Where people lacked the mental capacity to make decisions about their care, the provider had acted in their best interests, consulting with their representatives and applying for the correct legal authorisation to impose any restrictions on them.

The provider had suitable systems for dealing with, and learning from, accidents, incidents and complaints.

Rating at last inspection:
The last inspection of the service took place on the 25 and 26 September 2018 (published 1 November 2018). At this inspection we rated the service requires improvement. The key question, 'is the service well-led?' was rated inadequate. We identified breaches of seven Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to safe care and treatment, consent to care and treatment, nutrition and hydration, dignity and respect, person centred care, good governance and staffing. We issued warning notices in respect of the breaches of two Regulations relating to person centred care and good governance.

Whilst we found improvements in some of these areas during our inspection of 19 March 2019, the service remains rated requires improvement and has been rated as this for the last three inspections.

Why we inspected:
We inspected the service as part of our scheduled inspections based on the previous rating.

Enforcement:
We are taking action against the provider for failing to meet Regulations. Full information about CQC's regulatory responses to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The key question, 'is the service well-led?' has been rated 'Inadequate' at two consecutive inspections 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 will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

Follow up:
We will continue to monitor the service and will undertake another comprehensive inspection within six months or sooner if needed. We have invited the provider to meet with us to discuss how they plan to improve the rating of the service to at least 'good'. We have also asked them to provide us with a written action plan explaining this.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our Effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our Responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our Well-led findings below.

Coniston Lodge Nursing Home

Detailed findings

Background to this inspection

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

Inspection team:
The inspection was carried out by two inspectors, a nurse specialist advisor, a member of the CQC medicines team 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:
Coniston Lodge Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service provided both nursing and personal care and is registered to care for up to 92 people. At the time of our inspection, 48 people were living at the service. The majority of people were over the age of 65 years and some people were living with the experience of dementia.

The registered manager left in September 2018. The service had recruited a manager since this time, but they had left the organisation before they applied to be registered with CQC. The provider's representatives told us they had recruited a new manager who was due to start work at the service in April 2019. A registered manager like the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:

The inspection was unannounced.

What we did:
Before the inspection we looked at all the information we held about the provider. This included the last inspection report, action we had taken and the provider's response. We looked at notifications from the provider about specific incidents, safeguarding alerts and information from members of the public who had contacted CQC. We also looked at public information about the service, such as the provider's own, and other websites. We spoke with commissioners to ask for their feedback about the service.

During the inspection we spoke with four people who used the service and seven visiting relatives. We also spoke with staff on duty who included nurses, care workers, activity coordinators and the two deputy managers. The acting manager was on leave, but we spoke with the regional support manager, who worked at the service for four days a week and the regional director.

We observed how people were being cared for and supported. Our observations included using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not speak with us.

We looked at the care records for seven people who used the service, staff recruitment records for four members of staff, rotas, records of staff training, supervision and support, meeting minutes and evidence of quality monitoring. We inspected the environment and equipment being used.

We reviewed the medicine administration records (MAR) for 10 people and the sections in care plans relating to medicines for 12 people. We observed medicines administration, spoke to staff members and two people who used the service regarding medicines management.

At the end of the inspection, we gave feedback to the regional support manager, regional director and one of the deputy managers.

Following the visit, the regional support manager sent us additional documents we had requested, which included further evidence of quality monitoring, policies and procedures and information about mental capacity assessments and Deprivation of Liberty Safeguards (DoLS).

Requires Improvement

Is the service safe?

Our findings

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

Requires improvement - Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

● At the inspection of 25 September 2018, we found that whilst there were enough staff deployed to keep people safe, people sometimes had to wait for their care. At the inspection of 19 March 2019, we found there were not enough staff deployed to meet people's needs.

● People using the service and their relatives said that there were not enough staff available to meet their needs. They gave us specific examples about when they had to wait for care. One person told us, ''I ask late morning [if I can be supported to use the toilet] and sometimes have to wait until the afternoon. The staff say, 'You can use your pad' but who wants to sit in a wet pad?'' One relative told us, ''[Person] cannot walk and when [they] ask to go to the toilet, [they] have to wait a long time because the staff are busy.'' Other comments we received included, ''Sometimes at weekends they are short staffed and there seem to be a lot of agency (temporary staff)'', ''There are not enough, it is nothing against the staff, they work very hard, but you have to wait to be wheeled to the toilet'', ''There are not enough staff for any activities, people just sit in the lounge and fall asleep'' and ''The staff do not spend time talking to us.''

● We witnessed a number of incidents where people were calling out for help. On three of these occasions, people only received the assistance of staff when we intervened and requested that they were helped. In one instance a person was sitting on the floor of their bedroom calling for help. They had removed their clothing and continence pad and needed assistance to clean themselves. The nurse on the unit was present with one of the inspection team when this was first observed at 10.15am. We alerted the nurse to the situation, in case they had not noticed, as they had not responded in any way. The nurse did not offer any reassurance or assistance to the person. At 10.35am, we returned to see the person and found they remained in the same situation. We spoke with the regional support manager and requested the person was assisted without delay. The person received support at 10.50am. They had been requesting help for at least 35 minutes.

● There were not enough staff available to support people at lunch time. There were eight people in the Wren unit dining room at lunch time. The majority of staff left the room to assist people elsewhere, leaving only one member of staff in the room. Three relatives were in the room assisting the people they were visiting. One person, who needed assistance, was not served food until all the other diners at their table had finished their meals. The staff member then sat to assist them. Whilst this person was eating, the staff member left, in the middle of the meal, to take another person to the bathroom because there were no other staff available to ensure both people received assistance.

● An incident on Heron unit had resulted in one member of staff escorting a person to hospital. The

activities coordinator was sourced to carry out some of the caring duties. However, the staffing deployment on this unit did not meet people's needs. The staff were still helping people to get out of bed and wash at 11am and the morning medicines round was still taking place at 12pm. During this time, we noted a significant malodour from two bedrooms where people needed support with their personal care. Staff were not available to assist them as they were busy elsewhere. The regional support manager told us the situation on Heron unit was the result of the unexpected incident. However, the staff explained that there was no contingency for situations like this and staff absences or incidents always resulted in insufficient staffing levels.

● We spent some time observing the medicines round on Heron unit. The staff member responsible for administering medicines told us they did not have time to spend with people explaining about their medicines and making sure they felt comfortable and supported to take these. As a result, we witnessed four people refusing their medicines. The staff told us that they thought people would have taken these if they had been given more time.

● Call bells were placed within reach for most people and in bathrooms and toilets. But some people told us the staff were not quick to respond. One person said, ''They come, but they tell us they are dealing with another person and therefore we have to wait until they are free.''

● Throughout the inspection, we observed care which was task based and did not take account of people's perspective of the situation. This was particularly the case in both Wren and Heron units. For example, at mealtimes the staff brought and took away plates without explaining what the meal was or asking people about their enjoyment. People spent time in communal lounges without any staff interaction or activity. When the staff supported people with a need, they left the person immediately after the support. Therefore, people's experience of care was poor because the staff did not spend time with them meeting their emotional or social needs.

The above evidence demonstrates a repeated breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The regional support manager told us there was ongoing recruitment to employ more permanent staff to the service. Additional senior staff, including a second deputy manager and clinical lead, had been deployed to work alongside the nurses and care workers and to monitor their work.

● The provider had appropriate systems for recruiting new staff. These included checks on their suitability, such as references from previous employers, checks from the Disclosure and Barring Service regarding any criminal records, details of a full employment history, checks on their identity and an interview. All new staff took part in an induction which included assessments of their knowledge and competencies.

Using medicines safely

● At the inspection of 25 September 2018, we found medicines were not always being safely managed. At the inspection of 19 March 2019, we found some improvements had been made but people were still being placed at risk because medicines were not always managed safely.

● People did not always receive their medicines as prescribed. For example, the prescription details for one medicine included the instructions, 'Take half [a tablet] daily for one week and then one tablet daily.' On the day of the inspection (during the second week of this person receiving this medicine), the person was

administered half a tablet. The record of administration indicated that the person had continued to receive half a tablet rather than the full dose for the previous days.

● On the day of the inspection, some people refused to take their medicines. The staff member administering medicines stored these securely in the medicines trolley and told us they would attempt to administer them again later. However, there was no system to ensure that the person received their own medicines and not someone else's. There was also no record to alert other staff of the time the person was administered their medicines (when this was later than scheduled). Therefore, there may not have been sufficient time before the next dose was administered.

● There were not always records to document the application and removal of medicated patches. When records had been made, we found that the that staff were not safely rotating the site of application in line with manufactures guidelines.

● One person had been prescribed antibiotics. The person's care records did not contain details of the reason for these or how long they should be administered for. Nursing staff had not checked this information with the prescriber or pharmacist.

● The staff had created protocols in respect of PRN (as required) medicines. However, these were not always personalised and did not always give details about how an individual expressed pain or a need for the medicines. The staff had not always recorded the reason for administration of these

The above evidence demonstrates a repeated breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Medicines were stored securely and appropriately. The staff carried out checks on the storage of medicines to make sure temperatures remained within safe ranges.

● The staff responsible for administering medicines had received relevant training. Their competency and knowledge regarding safe medicines management had been assessed.

● Appropriate records were in place for people who received their medicines covertly, hidden in food or drink. These showed that decisions to administer medicines this way had been agreed by a multidisciplinary team and following assessments of people's mental capacity.

Assessing risk, safety monitoring and management

● At the inspection of 25 September 2018, we found that individual risks had been assessed and whilst there had been improvements in staff practice to mitigate some risks, there were also other risks which had not been mitigated. At the inspection of 19 March 2019, we found improvements had been made.

● The staff had assessed the risks to individuals relating to their care, physical and mental health needs. These assessments were appropriately detailed and included plans to minimise risks and keep people safe.

● During our inspection we observed staff supporting people to move around the home, both walking and using equipment. The staff did this appropriately, following guidance and ensuring people were safe and there were no hazards in the environment. People being supported to move using a hoist were safely cared for. The staff checked the equipment before using this and explained to the person what they were doing.

Staff who supported people to eat and drink did this appropriately. They made sure people were positioned correctly and they were patient and let people eat at their own pace.

● The environment was appropriately maintained. There were no obvious hazards and we saw the provider had undertaken regular checks on the environment and equipment being used. There were suitable fire safety procedures and the staff were aware of these and what they would do in an emergency. Individual evacuation plans had been created for each person to describe the support they would need in an emergency. The provider had assessed the risks relating to the environment and there were regular checks on electrical equipment and water supplies to make sure these were safe.

Systems and processes to safeguard people from the risk of abuse

● People told us that they felt safe at the service. Their relatives also told us they felt people were safe. However, one relative told us that personal items (of personal value only) had 'gone missing' from the person's room. Another relative told us that they thought their relative's wheelchair was sometimes used for other people. During our inspection, we saw that at one point a visitor started to assist a person (not their relative) with their meal. We discussed this with the regional support manager who told us they would make sure visitors knew that they should not do this because of risk that people may choke.

● The provider had a procedure for safeguarding adults. The staff had received training regarding this and were able to tell us what they would do if they suspected someone was being abused or at risk of abuse. There had been a number of incidents which the provider had raised as safeguarding alerts with the local authority. Records showed that they had taken appropriate action to keep people safe and investigate allegations of abuse.

Preventing and controlling infection

● There were suitable procedures to ensure the environment remained clean and the risk of infection spreading was minimised. The staff were supplied with protective clothing, such as gloves and aprons. We saw that they wore these and disposed of them correctly. The staff received training regarding infection control. There were enough cleaning staff deployed to keep the service clean. The provider undertook regular checks regarding infection control and cleanliness.

Learning lessons when things go wrong

● There were systems to learn from incidents, accidents, complaints and other adverse events. The staff were able to tell us what they would do in specific situations. They said they spoke about accidents and incidents in handover and team meetings, so they could learn from these. All accidents, incidents and complaints were recorded and there was evidence in these records that action had been taken to reduce the risk of reoccurrence.

● The managers checked and analysed the different events at the service. They discussed these with senior managers to make sure appropriate action had been taken. The provider made sure there was regular senior managerial staff working at the service. This meant they could work with the staff to identify where improvements were needed and support the staff to make the necessary changes.

Requires Improvement

Is the service effective?

Our findings

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

Requires Improvement - The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance

● At the inspection of 25 September 2018, we found consent to care and treatment was not always sought in line with legislation and guidance. At the inspection of 19 March 2019, we found improvements had been made.

● The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

● People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

● We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

● The provider had carried out assessments of people's mental capacity in relation to specific decisions. The assessments included information about how best to communicate the decision with the person. Where people had been assessed as lacking mental capacity, there was evidence that their representatives had been consulted to make sure decisions were made in their best interests.

● The provider kept a record to show when mental capacity assessments had been made and needed to be reviewed, whether DoLS authorisations had been requested or approved, and the dates these needed to be reapplied for.

● Whilst the staff explained they had received training in respect of the MCA, they were not always able to tell us about this or how they applied it in their work. We discussed this with the provider's representatives who agreed to support the staff to have a better understanding of this.

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

● At the inspection of 25 September 2018, we found that people were not always supported to have enough to drink to stay safely hydrated. At the inspection of 19 March 2019, we found improvements had been made.

● The care plans for each person showed that changes in weight had been recorded and responded to. There was evidence that the staff had made referrals to other healthcare professionals, such as dietitians, when needed. There had been increased monitoring where people were identified as at nutritional risk. The managers recorded a monthly analysis of changes in weight and action that had been taken to support people.

● There was evidence that fluid intake was monitored, and that staff were alerted via the electronic care planning system when people's fluid intake was too low. We saw that drinks were available and offered to people in both communal rooms and their bedrooms.

● People told us they liked the food. Their comments included, ''We get a lot of food'', ''The food is lovely'' and ''It is good, we get choices.''

Staff support: induction, training, skills and experience;

● The staff did not always have the skills and experience needed to provide effective care and support. For example, we witnessed situations where people were distressed and had to wait for care. When the staff offered support, they did not apologise or offer reassurance or comfort. Support delivered in this way did not reflect best practice, nor was it in line with current guidance. For example, the National Institute for Care and Care Excellence (NICE) guidance [NG86] states, 'Practitioners working in all settings where care and support is delivered should respond flexibly to the priorities a person might identify each day.' Our examples illustrate this was not always happening.

● People who were supported at meal times received functional and practical support. However, the not all of the staff demonstrated the skills to provide personalised care. We spoke with some staff about people's needs and how they would respond in specific emergency situations. Not all of the staff were able to explain what they would do or how to care for people in a safe way. We discussed our findings with the provider's representatives who agreed to investigate this and provide additional support and training for the staff where needed.

● People's poor experience of having to wait for a response from staff and the way in which staff sometimes responded meant support was not being delivered in line with current guidance to achieve effective outcomes and indicated that training had not always been embedded in staff's day to day practice.

● The staff told us they received a good range of training. We saw evidence of this. The provider had their own training department and was able to organise training specifically to meet the needs of the service. All the staff had undertaken training in line with the Care Certificate. The Care Certificate is a nationally recognised set of standards that gives staff an introduction to their roles and responsibilities within a care setting. Some staff were also being supported to undertake vocational qualifications and, for nurses, to maintain their clinical skills.

● New staff undertook an induction into the home. The regional support manager told us that they worked alongside trusted, experienced and skilled members of staff so that they learnt good practice and developed the skills they needed to care for people.

● There were regular meetings for the staff to discuss people's needs and other aspects of the service. The staff told us they had the information they needed to care for people and felt supported. The staff had opportunities for individual meetings with their line manager to appraise their work and plan how they wished to develop in their role.

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

● The service was divided into different units. At the time of the inspection, three units were in use. Each unit had a dining room, lounges and individual bedrooms with en-suite facilities. Corridors were wide and equipped with hand rails. There were accessible baths, showers and equipment to support people to access these. People's mobility needs and risks to their safety had been assessed, and equipment was provided to meet their needs and mitigate these risks. For example, bedrails, alarmed mats in case people fell, profiling beds and hoists.

● The layout of the environment was clean and functional. The décor was in relatively good condition. There were some features designed to provide a homely environment, such as pictures, a 'cinema lounge' and a small number of interactive features. Although, there was room for further improvements to support orientation and make the environment homelier. The provider was aware of this and had plans to develop the environment further.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

● People's healthcare needs had been assessed and planned for. Care plans included details about specific conditions and the support they needed. The staff monitored people's health and wellbeing and recorded this. They had responded appropriately when people's health had deteriorated or following an accident or period of ill health.

● Care records included details of the healthcare professionals involved in people's care. There was evidence that people had regular appointments and that the staff made appropriate referrals regarding changes in people's health. The provider employed nursing staff who provided clinical care and support. The GP visited the service for regular rounds and there was evidence of good communication between them and the staff.

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

● The staff had carried out assessments of people's needs before they moved to the service. These included basic information about their needs, including their wellbeing and social interests, religion, communication, personal care needs, skin integrity, safety, medical conditions and mental health needs. This meant that care could be planned to meet these needs.

Requires Improvement

Is the service caring?

Our findings

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

Requires improvement - People did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence

● At the inspection on 25 September 2018, we found the staff did not always treat people with respect, respond to situations in a caring way or consider their privacy and dignity. At the inspection of 19 March 2019, we found this was still the case.

● We witnessed incidents and interactions where staff did not respect people or consider their emotional wellbeing. For example, on Heron unit one person who did not have clothes on their bottom half and needed assistance to clean themselves was left sitting on their bedroom floor for 35 minutes before they were assisted. Staff had observed this situation, but had not provided help, comfort or reassurance before this. Nor had they closed the door to offer the person some privacy. When two members of staff attended to support the person, they spoke with each other in the doorway before they spoke with the person. The person was upset and repeatedly apologised, stating that they had, ''Made a mess.'' The staff response did not calm or reassure the person, as they answered, ''Yes – we will do it now'' and then continued to speak with each other.

● During an incident in Wren unit at lunch time, the staff member assisting one person with their meal left the person to support another person to go to the bathroom. They did not explain what they were doing or apologise. When they returned ten minutes later, they carried on supporting the person with their meal without explanation or apology.

● The staff on both Heron and Wren units mostly focussed on the tasks they were performing rather than the needs and perspectives of the people they were caring for. Their interactions were around the tasks they were performing. Whilst the staff were generally polite, they did not spend time talking with people, or ask about their wellbeing, enjoyment of food or what they were doing or offer them choices about where they wanted to go, what they wanted to do and, in some cases, what they wanted to eat.

● The provider had a system of 'resident of the day' where one person on each unit was supposed to receive specific additional support. This included updating their care records and spending time with them to make sure they were happy with different aspects of their care. On the day of our inspection, the person who was 'resident of the day' on Heron unit was in bed until 10.30am. After they were supported to get up, they spent the morning alone in their room watching television. Care records showed that they had been given their breakfast at 11.29am. Care records showed that between 6-10am that day they had received 12 minutes of interaction from the staff. We heard them calling out at 12.25pm. We alerted the staff to this. The staff

attended but just offered the person a cup of tea and left again. We noted that the person's glasses were lying on their bedroom floor. Care records showed the person was not able to mobilise independently and therefore could not have dropped these themselves.

● The staff sometimes used language and terms in care records which did not show respect or an understanding of people's feelings and needs. For example, they focussed on the tasks rather than people's feelings about the care they received. We saw the staff recording that people's ''Compliance was good'' and ''[Person] remains restless but fairly manageable.''

The above evidence demonstrates a repeated breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Notwithstanding our findings described above, people using the service and their relatives told us they found the staff kind and caring. Some of their comments included, ''They show real patience'' and ''They are very kind to [person]'', ''I have no complaints, they are always kind and caring.''

● Furthermore, we also observed some kind interactions. In Robin unit, care workers there spent time sitting with people, talking and supporting individual activities, such as colouring and playing games. People were brought drinks and snacks when they asked and did not have to wait for care. Staff supporting people to move, using hoists, offered people reassurance. The staff also ensured people's clothing was appropriately adjusted to maintain their dignity when being supported to move.

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

● There were no specific arrangements to promote an environment where the rights of people identifying as LGBT+ (lesbian, gay, bisexual or transgender) were promoted. However, the regional support manager told us they had arranged for some staff training to take place to help them have a better understanding about providing a more inclusive environment. This has not happened at the time of our inspection. They also said there was a poster by the office printer which had some information for staff about LGBT+ rights, although there was nothing on display for people using the service or visitors.

● People told us they had opportunities to practice their faith. There were visiting priests and church services took place at the service. The regional support manager told us that relatives supported some people to attend places of worship. Some people we spoke with told us they would like more opportunities to celebrate their culture and one person explained they would like a wider choice of food to meet their cultural needs. The regional support manager told us outside caters provided culturally appropriate meals for some people.

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

● People told us that they were able to make choices about their care and support. Their relatives explained they had been consulted and were asked to make decisions about people's care.

● People told us they had been asked whether they had preferences regarding the gender of the staff who supported them. We saw that this was also recorded in care plans, where people had made a specific request.

Requires Improvement

Is the service responsive?

Our findings

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

Requires improvement - People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

● At the inspection of 25 September 2018, we found people did not always receive personalised care which was responsive to their needs. At the inspection of 19 March 2019, we found improvements had been made with care planning documents. However, people were still not always receiving personalised care which met their needs.

● Throughout the inspection, we witnessed incidents where people had to wait for care and support. This included waiting for support with personal care, such as washing and dressing as well as waiting to be assisted with meals.

● People using the service and their relatives told us there was not enough social and leisure activities to meet their needs. One person said, ''There is an activities lady, but she is only one person and it is not enough.'' Another person said, ''The staff do not have time to sit and chat, there is not really enough to do.''

● People's records of care indicated that they did not always have opportunities to participate in activities they enjoyed or be offered a range of activities. For example, one person's care records for March 2019 recorded the only activities they had participated in as one day of knitting, arts and crafts on the same day and three occasions when they had a visitor. The person's care plan included the objective, ''Needs to get involved in activities, care staff to keep [person] active during the days.'' The care plan also stated, ''[Person] loves knitting, staff to encourage [person] to come out of [their] room where [they] can sit with other residents and knit.''

● The March 2019 care records for another person recorded they had attended a church service and had one visitor in March. There were no other recorded activities, and care notes referred only to personal care, eating and drinking and the person's state of mind. This information was sometimes confusing, for example on two occasions in the previous week, staff had recorded, ''Fairly settled day, observed to be confused.'' There was no further explanation about these statements or information about what the person had done.

● The care plans did not always give personalised details about people's preferences or how they wanted to be cared for. The plans often used standard phrases which were the same for several people and task based and did not tell the staff how to support people or what their individual needs were. For example, ''I eat over half of most meals including a total of four servings of protein per day'' and ''More sleeping than usual after meals – more than once.''

The above evidence demonstrates a repeated breach of Regulation 9 of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

● The provider had improved care planning information since the last inspection. This included ensuring care plans were developed for health care conditions. These gave information about the person's condition, any risks associated with these and how they should be cared for. The regional support manager told us they had overseen the development of these plans.

● The provider had introduced a new electronic care planning system which was linked to hand held devices carried by the staff. This meant they could log the care they provided directly from the device and also access information about people's care needs whilst supporting them. The provider was still in the process of transferring information from paper records onto the system. But it was already being used to record the care given and the staff told us they found it accessible and helpful. They explained that they spent less time on paperwork and were able to spend more time with people using the service because of this change.

● The provider employed a physiotherapist who worked at the service three days a week. This enabled them to assess people's mobility needs and provide individual support as well as guidance for the staff.

Improving care quality in response to complaints or concerns

● People using the service and their relatives told us they knew how to make a complaint or what they would do if they were unhappy about something. Their comments included, ''I can tell the manager or the nurse'', ''I don't have any complaints, but I would speak with the nurse'' and ''If it was just a little thing I would ask the carers.''

● People using the service were provided with information about how to make a complaint. This was also on display. The provider kept a record of all complaints and how these had been responded to. The regional support manager told us they worked at the service four days each week and regularly spoke with families and visitors to discuss their concerns. They felt that communication with stakeholders had improved and they were able to resolve concerns before these escalated into complaints.

End of life care and support

● Some people living at the service were supported at the end of their lives. Their care plans included information about their preferences and specific needs they had. The staff worked closely with palliative care teams and other professionals to make sure people had access to the pain relief and services they needed.

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

Inadequate - There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care; Working in partnership with others

● At the inspection of 25 September 2018, we found that the provider's systems for assessing, monitoring and mitigating risks and assessing, monitoring and improving the quality of the service were not always effective. At the inspection of 19 March 2019, we saw that the provider had introduced further processes for monitoring and improving the quality of the service, but these were not always operated effectively enough to ensure people received a high-quality service.

● People were not always safely cared for. Whilst there had been improvements in the way medicines were managed, the provider's systems had failed to identify that people did not always receive their medicines as prescribed.

● People did not always have a good experience of the service. They sometimes waited for care, the staff did not always treat them with respect and their needs were not always being met. The provider's systems- to improve this had not been operated effectively. Whilst some similar concerns relating to engagement, privacy and dignity had been identified during the provider's own quality audit of February 2019, they had not taken sufficient action to make the necessary improvements. This was demonstrated by the examples we saw of people waiting for care whilst being left in undignified and distressing situations.

● We identified breaches of Regulations relating to person centred care, dignity and respect, safe care and treatment and good governance at the inspections of 23 February 2018 and 25 September 2018. We issued warning notices in respect of person centred care and good governance following the last inspection telling the provider they must make the required improvements by 31 December 2018. Whilst, we identified some improvements these had not been sufficiently established or maintained.

● Whilst the provider's senior managers had provided support for the service and there were examples of personalised care, the overall culture did not assure the delivery of high quality person centred care. Care planning and delivery continued to focus on tasks rather than meeting individual needs in a personalised and caring way.

The above evidence demonstrates a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At the inspection of 25 September 2018, we found the provider did not always maintain complete and contemporaneous records of the care provided to service users. At the inspection of 19 March 2019, we found improvements had been made. A new electronic care planning and recording system allowed the staff to enter information about care they had provided using hand held electronic devices. These provided information which could be accessed by managers and senior managers remotely. Alerts were generated if people did not receive specific planned cared. This system meant that senior managers could identify and respond to concerns when they happened.

● The registered manager left the service shortly before the last inspection. The provider's regional support manager and area manager had been working at the service to provide managerial support. The provider's representatives told us they had recruited a permanent manager who had not yet started work there at the time of our inspection. Since the last inspection, the provider had recruited a second permanent deputy manager to work at the service. They also employed a clinical lead who worked at this and another service to provide clinical oversight.

● The staff, managers and senior managers carried out a range of checks and audits. These audits included analysis of accidents, incidents and complaints and a quarterly assessment of the whole service based on the key questions asked by CQC at inspections.

● The managers working at the service completed monthly statistical reports regarding changes in people's weight, people's wounds , safeguarding alerts, complaints, accidents and incidents, medicines errors and staff supervision. There was a record of actions taken regarding any adverse events. These reports were shared with senior managers.

● People using the service and their relatives were generally happy with the service and the care they received. People said they particularly liked the food, and felt the care workers were kind, polite and friendly. Some people told us they would like activities to be improved and for the staff to have more time to spend with them.

● The staff told us they enjoyed working at the service. They said that they felt unsettled by the lack of a permanent manager, but they gave positive feedback about the senior management support from the provider.

● The provider's representatives met with the local authority, clinical commissioning group and health service representatives to discuss people using the service and how their needs could be met.

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 The registered person did not ensure that care and treatment of service users was always appropriate, met their needs and reflected their preferences. Regulation 9 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not ensure that care and treatment was always provided in a safe way for service users because they did not ensure the safe and proper management of medicines. Regulation 12(1) and (2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not always effectively operate systems and processes to assess, monitor and improve the quality and safety of the service or assess, monitor and mitigate the risks to service users. Regulation 17(1) and (2)(a) and (b)

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 Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered person did not ensure that service users were always treated with dignity and respect. Regulation 10(1)

The enforcement action we took:

We have issued a warning notice telling the registered person they must make the improvements by 31 May 2019.

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 registered person did not ensure that sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed to keep service users safe and meet their needs. Regulation 18(1)

The enforcement action we took:

We have issued a warning notice telling the registered person they must make improvements by 31 May 2019.