Newbloom (Dundoran) Limited

Dundoran Nursing and Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Dundoran Nursing and Residential Home provides accommodation for up to 39 people who need help with nursing or personal care. At the time of the inspection 26 people lived in the home. The majority of people living in the home, lived with dementia or other mental health needs.

People's experience of using this service and what we found
People's needs and risks were not properly assessed, monitored or managed placing people's health, safety and welfare at risk. A lack of adequate information on how to manage and monitor risk meant staff did not have sufficient guidance on how to meet people's needs safely or in a person centred way.

People's health and medical needs were not properly described, and some people's medical appointments and reviews had not been followed up by nursing staff. Information about some people's clinical needs and the care they required was contradictory. Clarification from relevant medical professionals had not been sought.

Records in relation to the care people received were poorly maintained, not always accurate or easy to follow. They did not show that people received the care they needed with regards to skin integrity, personal hygiene, diet and fluids or medicines.

There was a lack of care planning or provision for people living with dementia or other mental health needs to promote their independence and well-being. The home did not always promote a therapeutic or relaxing environment for people living with dementia or other mental health needs. The loud and noisy environment increased the risk of people becoming distressed and agitated or disorientated.

The cleanliness, hygiene and condition of the premises and equipment were poorly maintained increasing the risk of the spread of infection. There were several fire doors across the service which did not close properly which meant they would not be effective in the event of a fire. There was no hot water in some people's bedrooms or in some communal bathrooms to promote good hand and personal hygiene.

There were insufficient numbers of suitably skilled and experienced staff deployed across the service to meet people's needs and keep them safe. Staff recruitment was not robust and failed to ensure people employed were safe and suitable to work with vulnerable people. Staff were not properly supported in their job role and some staff had not completed appropriate training to ensure they had the skills and knowledge to support people effectively.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. The use of physical restraint had been used without robust processes in place to identify, agree and monitor its use.

The service lacked clear leadership and governance. The systems and processes used to assess, monitor and improve the quality and safety of the service were not robust and not used effectively to mitigate risks. Audits and checks carried out at the service were inconsistent and not regularly completed. Where actions had been identified these had not always been acted upon in a timely manner. Provider oversight of the management of the service was poor and it was clear they had not fully identified or, recognised the seriousness of the concerns found during our inspection. This exposed people to unnecessary risk.

At the time of our inspection, there was no registered manager in post and the previous manager had left. An interim manager and a clinical lead were supporting the service, both of whom were open and transparent during our visit. After the inspection, the provider submitted an urgent action plan of improvements to CQC. The Local Authority were also notified of our concerns and have taken action to support the service.

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

Rating at last inspection
The last rating for this service was good (published 01 July 2022).

Why we inspected
This inspection was an urgent responsive inspection prompted by information shared by the Local Authority and members of the public. A decision was made for us to inspect and examine those risks in a focused inspection of the domains of safe and well-led. During the inspection however, significant concerns were identified in other areas of service and a decision was made to open up the inspection to a full comprehensive inspection covering all five domains.

We found evidence during the inspection that people were at serious risk of harm. Following the inspection, the provider was asked to, and submitted an urgent action plan for improvement. The Local Authority were also informed of our concerns and took action to mitigate risks and ensure the safety of people living in the home.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Dundoran Nursing and residential Home on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to Regulation 9 (Person Centred Care); Regulation 11 (Need for Consent); Regulation 12 (Safe Care and Treatment), Regulation 17 (Good Governance), Regulation 18 (Staffing) and Regulation 19 (Fit and Proper Persons) at this inspection.

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

Follow up
We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect. We will work alongside the provider and local authority to monitor progress against the provider's action plan for improvement.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Dundoran Nursing and Residential Home

Detailed findings

Background to this inspection

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

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

Inspection team
This inspection was undertaken by three inspectors 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
Dundoran Nursing and Residential Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Dundoran Nursing Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

At the time of our inspection, the manager of the home had recently been dismissed. They were not registered with CQC whilst employed at the home. During our visit, we were assisted by an interim manager and clinical lead.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 08 February 2023 and ended on 15 February 2023. We visited the service on 08 and 10 February 2023.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the Local Authority, the NHS End of Life Team, the NHS Infection Control Team, the NHS Tissue Viability Service and Merseyside Fire Authority. We used all this information to plan our inspection.

The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection
We spoke with the provider, the interim manager, two clinical leads, a nurse, the activities co-ordinator, a team leader, a care assistant, a visiting professional, an external professional involved with people's medicines, a visitor to the home, six people who lived in the home and five relatives.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

- Records about medicines did not show that they were managed safely. Records were not always accurate and did not show that some people received their prescribed medicines.
- Some people received food and drink through a PEG tub into their stomach. The guidance in place to ensure this was done correctly was contradictory and professional advice had not been sought. This meant it was difficult to tell if people's nutritional support was being managed safely.
- Some people required high risk medicines such as oxygen and blood thinning medicines. Staff lacked clear guidance on the risks associated with these medicines and how to administer them safely. For example, nursing staff had temporarily increased the dose of one person's oxygen medication without discussion or the approval of appropriate medical professionals. This meant there was no evidence this practice was safe.
- Some medicines needed to be given before or after food, yet they were not administered in this way. This increased the risk of them being ineffective.
- It was unclear whether some people's medicines were in a safe format for them to have. For instance, some people had swallowing difficulties and were risk of choking. Despite this they were being given medicines in tablet format. Tablet medication can pose a choking risk to people with swallowing difficulties. Despite this, no risk assessment had been undertaken or medical advice sought to establish the safest method.
- Not all medicines could be accounted for, including two doses of controlled drugs (CDs). There were no robust systems in place to check that the right amount of medication was in the home. A controlled drug is tightly controlled by the government because it may be abused or cause addiction.
- Staff lacked adequate guidance on how to administer some medicines. For example, 'as and when' required medicines, medicines with variable doses, and prescribed creams. This meant there was a risk that these medicines would not be given consistently or when needed.
- Medicines were not always administered safely by nursing staff. The ability of some staff to administer medicines safely had not been assessed.

The management of medication was unsafe. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- Staff lacked adequate information on people's needs, risks and care. This placed people at significant risk of receiving inappropriate and unsafe care.
- People's medical needs were not always assessed, and staff did not have adequate information on what

these conditions were or how to care for people safely. People's nursing needs were not always followed up with other healthcare professionals to mitigate risks to people's health, safety and wellbeing.
● The environment in which people lived was not adequately maintained or safe. Some bedrooms and toilets did not have access to hot water; some fire doors did not close properly to prevent the spread of fire. The over-head lamps above some people's beds did not work; parts of the home were cluttered, and the dining area was too small for everyone to be able to eat their meal at a dining room table.
● There were personal items stored in communal corridors and people's bedrooms. For example, there were prescribed creams in people's rooms, razors and cans of deodorant spray in corridor areas. These items can be a safety hazard for people living with dementia who may not remember how to use these items appropriately or in a safe way. No risk management strategies were in place to mitigate the risk of harm.
● Some of the pressure mats in people's bedrooms, designed to alert staff when people got out of bed to prevent a fall were not plugged in properly. This meant they would not ring and alert staff to a person's movements or to a potential fall.

The provider had not ensured risks to people's health, safety and welfare were adequately assessed, and mitigated against to prevent avoidable harm. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Staff recruitment was not managed safely. Some of the required pre-employment checks were not completed to ensure staff working in the home were safe to work with vulnerable people. For example, gaps in employment were not always investigated, clear evidence of a full DBS check was not always available, and where people's previous employment history had flagged up concerns, these had not always been investigated or risk assessed to ensure people were suitable to work in the home.

Safe recruitment practices were not fully followed. This was a breach of Regulation 19 (Fit and Proper Persons) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff rotas were not always accurately maintained to show which staff members were on duty. For example, one nurse had signed for medicines when according to the staff rota they were off work sick. On some days the rota showed there was no nurse on duty. The interim manager told us the previous manager was the nurse on duty on these days, but the rota had not been updated to reflect this.
● The home did not always have sufficient permanent staff on shift and at times relied heavily on agency staff. This was not good practice.
● Some people require one to one support from staff. The systems in place to ensure people always had this support were not robust. This increased the risk of people not receiving the one to one support they needed to keep them safe.
● Staff spoken with told us there were not enough staff on duty to meet people's needs. They told us a lot of people required two staff to support them at any one time, and there was not enough staff to provide this support at all times.
● Some of the people living in the home told us at times they had to wait for support. Comments included, "There's a buzzer, it does take a while (for staff to come). At weekends it's worse" and "It takes quite a while (for staff to come). You just have to wait until they get there".
● One relative told us, "One weekend I went in and they [person living in the home] were in bed being fed by the carer but there was only 3 or 4 members of staff there. They were clearly understaffed, so I took over. Then I noticed they were in their own urine. Two staff had gone to lunch so there were only two to look after the whole floor. They apologised that they were understaffed".

There were not enough staff on duty at all times to meet people's needs. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● We were not assured that the provider was admitting people safely to the service. For example, two people were admitted to the home during an outbreak of flu, without the safety of these admissions being risk assessed prior to admission.

● Parts of the home and its equipment were unclean and unhygenic. For example, one person's commode contained faeces; there was a smear of faeces on the floor of a communal bathroom; some of the mobility equipment, pressure cushions and alarm mats in use were dirty or not in good repair and there were personal items in communal bathrooms that increased the risk of contamination. The medication room was also dirty and cluttered.

● Wirral NHS Infection Control Team visited the home in November 2022. They identified a list of high priority infection control actions and an action plan for improvement was agreed with the provider. During our visit, we noted that some of these actions had not been completed in accordance with the action plan.

● There was no hot water in some of the bedrooms or communal bathrooms making good hand hygiene and good personal hygiene difficult.

● The risk of Legionella bacteria developing in the home's water system was not safely managed to ensure the risk of people contracting Legionella was mitigated against.

Risk of the spread of infection was not managed adequately. This was a breach of Regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There was ample supplies of PPE and we were assured that the provider was using PPE effectively and safely.

● People living in the home were vaccinated against COVID-19 to prevent the spread of this infection.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

● Safeguarding incidents were recorded on the provider's accident and incident system. The Local Authority Safeguarding Team and CQC were not always notified of these incidents. This meant the systems and processes in place to safeguard people from the risk of abuse had not always been followed.

● People told us they felt safe living in the home and with the staff team.

Inadequate

Is the service effective?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- People's needs, risks and choices were not adequately assessed, or care planned. Care was not always provided in a safe or effective way in line with standards and guidance.
- There was a lack of adequate information in people's care files about people's medical needs and the involvement of other health care professionals.
- We found that some people had not attended appointments in relation to their health with no explanation. It was not clear if people therefore were in receipt of the right level of nursing care a result of this.

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

- People's dietary needs were assessed but information was sometimes contradictory. Furthermore, records did not always show people received sufficient amounts to eat or drink for them to maintain a healthy and balanced diet.
- Some people had swallowing difficulties which meant they required a special diet and/or thickened fluids to prevent them from choking. Dietary records did not always show people received the diet or thickened fluids they needed to prevent them from choking or developing aspiration pneumonia (when food or drink goes into the lungs rather than the stomach).
- There was a choking kit in place to help clear people's airways in the event of a choking episode. Staff had not been shown how to use this equipment and some staff were not even aware there was a choking kit in place.

People's needs and risks were not properly assessed or managed to ensure that people's health and well-being were supported in accordance with standards and best practice. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- Some staff had received an induction into the workplace, but others had not. One staff member told us they did not have a proper induction, but did shadow another member of staff for a "couple of days".
- A significant number of staff had not completed the provider's mandatory training programme. For example, 52 staff out of 58 staff had not completed training on how to provide person centred care. 42 staff had not completed dementia awareness training. 47 staff had not completed food hygiene training and 37

staff had not completed training in privacy and dignity. There was also no evidence that staff were trained in the use of physical restraint, despite some people's care plans advocating its use.
● 52% of the staff team had not received sufficient supervision or support in their job role in the last 12 months. Two staff members confirmed this. There was also little evidence that staff had received an annual appraisal of their skills and abilities to ensure they were doing their job role effectively.

Staff had not received appropriate support or training to carry out their job role effectively. This was a breach of Regulation 18 (Staffing) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether appropriate legal authorisations, were in place, when needed, to deprive a person of their liberty. We also checked whether any conditions relating to those authorisations, were being met. We found improvements were required.

● We looked at the mental capacity assessments for people whose ability to make certain decisions about their care and welfare was in question. We saw that people's capacity to make a range of different decisions about their care had been assessed at the same time on the same day.
● Conducting multiple capacity assessments on the same day at the same time is not good practice. It would have been a confusing and tiring process for people living with dementia or other mental health conditions to participate in, which may in turn may have impacted on their ability and motivation to provide reliable responses.
● Some of the assessments were generic covering lots of different areas with no specific decisions or timeframes defined and some of the recorded conversations did not always relate to the decision being made.
● The assessments conducted were undertaken by a member of staff who worked in a sister home, who did not work personally with the people being assessed. Despite this, in most cases, no other persons or professionals who knew the person well were part of the best interest process. This meant there was a risk that the person's wishes or preferences would not be adequately represented. This practice did not reflect the principles of the MCA.
● Some people's care records advocated the use of the physical restraint to keep them safe, as and when required. Good practice in relation to obtaining legal consent for the use of restraint was not followed and there was no adequate oversight of its use to ensure it was used appropriately in accordance with the MCA.

People's consent was not always obtained in accordance with the Mental Capacity Act 2005. This was a breach of Regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● The design of the service was not adequately utilised to meet the needs of people living with dementia or other mental health needs. Some people living in the home were placed in a crowded lounge and dining area for most of the day. This environment was chaotic, noisy. Some of those people had care plans that stated they became upset and agitated by noisy and loud environments. There was little evidence the provider considered the impact of this environment on people's mental well-being

● The home had a secure garden for people to enjoy if they wished. Access to the garden area was however limited as the doors to this area were kept locked, restricting people's access to it. There were also other quieter areas of the home that were not maximised such as the conservatory and a second lounge area.

We recommend that the provider reviews best practice guidance on dementia friendly environments such as that recommended by the NHS and Social Care Institute for Excellence.

● The home had a passenger lift to enable people with mobility problems to access their bedrooms.

● The home was pleasantly decorated in some areas, with musical themes such as the Beatles and Abba with music was playing in corridor areas for people to listen to.

Requires Improvement

Is the service caring?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported;
- Some people's diverse needs and wishes had not been properly assessed to ensure staff were able to provide good care.
- Some aspects of people's care did not show they were supported well. For example, during lunch two people were sat with their hot meals in front of them, without attempting to eat for approximately 20 minutes before staff offered them any help. Neither were offered an alternative or fresh meal even though their food must have been cold by thes time support was offered. We saw that both people ate very little.
- There was a high use of agency staff which meant people were not always familiar with the staff member who was caring for them and vice versa. On some days, the number of agency staff on duty outweighed the number of permanent staff.

Respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence
- A small room contained confidential care records. This room was not fully secure. Care files and other records were piled behind the door, making it difficult to open fully, but there was still a risk that this room could be accessed inappropriately. This meant people's right to confidentiality could be breached.
- Some staff had not received training in privacy, dignity, equality or diversity to ensure they had the skills and knowledge to promote best practice in these areas.
- Most people told us that staff were kind and caring. Our observations confirmed this. Staff spoke about the people they cared for warmly and appeared to know the 'person' well.

Supporting people to express their views and be involved in making decisions about their care
- The provider had not ensured they had done all that was reasonably practicable to support people to express their views and make decisions about their care in accordance with best practice.
- There were opportunities for some people living in the home to attend residents' meetings where they could express their views on the care they received. However, some people living in the home were unable to verbally express their views. There was little evidence that relative meetings also took place, to ensure the views of those people unable to communicate, were represented.

Inadequate

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant services were not planned or delivered in ways that met people's needs.

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

- Care plans were not always up to date and reflective of people's current needs. For example, two people's care plans gave conflicting information on their physical ability to use the toilet and shower safely and the support they required. We also found conflicting advice in other people's care plans with regards to their dietary needs, cognition, ability to communicate and mobilise. This lack of accurate and up to date information increased the risk of people receiving care that did not meet their needs.
- There was no evidence that people and their relatives were involved in regular reviews of their care to ensure it continued to meet their needs and wishes. Reviews of people's care were done monthly but were very brief, and did not reliably identify changes in people's needs and care.
- The majority of people living in the home lived with dementia or other mental health needs. There was no adequate information or consideration of these needs and the impact they had on people's lives in order to ensure staff knew how to support people's emotional needs and mental wellbeing in a person centred way.
- On the days we visited, the communal lounge area was very chaotic. It was a loud, noisy. Music or the TV played loudly for most of the day with staff shouting, singing and activities taking place. There was also a range of visitors in and out. It was not a therapeutic or relaxing environment for people to live in, especially for those living with dementia or other mental health needs.
- During lunch, staff members shouted over to each other whilst serving meals, music played, and domestic staff used noisy cleaning equipment in the corridor outside of the dining area. It was not a pleasant dining experience or conducive to promoting good food and drink intake or people's dignity.
- During our visit, whilst most staff and person interactions were warm and familiar, they were not always person centred. During lunch one staff member supported two people to eat at the same time, with little interaction. Another staff member stood up whilst supporting people to eat and another staff member pulled a person away from the dining table with no warning, which startled them.

People's care was not always person centred to ensure their needs and preferences were met. This was a breach of Regulation 9 (person centred care) Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- People's bedrooms were personalised with the things that were important to them.
- Some people's care plans contained information about their personal lives and the things that were important to them in their day to day life.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the

Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● People's communication needs were not accurately identified. For example, care plans contained contradictory information about their needs in relation to sight and hearing.
● There was little evidence that pictorial aids were used to help people express their views or communicate with staff on a day to day basis. For example, there were two choices at mealtimes, these were handwritten on a small blackboard on the wall that was not always clear. People living with dementia may have difficulty choosing and deciding on what they want to eat and drink as they are unable to remember what certain foods or meals look like. Or they may have trouble with visual perception which makes reading written information difficult. Pictorial menus therefore help boost recognition and decision making in relation to choosing what to eat and drink.
●There were some pictorial aids around the home to help people identify where the toilet, lounge or their own bedrooms were, which helped them make sense of their environment. There was little evidence that pictorial aids were used to help people express their views or communicate with staff on a day to day basis.

People's communication needs were properly identified, and people were not supported to communicate in a way they could understand. This was a breach of Regulation 9 (person centred care) Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

End of life care and support
● No-one living in the home at the time of the inspection was in receipt of end of life care.
● Some people had 'do not resuscitate' decisions in their care file, some of which had not been reviewed on admission to the home or after a period of ill-health. This was not good practice.
● Some people did not have end of life care plans in place, some care plans were generic. This did not show that the provider understood the importance of ensuring people's end of life wishes were discussed and respected.
● None of the staff team had completed the provider's mandatory 'Dying, death or bereavement' training. However, the home had achieved the NHS End of Life Accreditation and recently received additional training and support from the NHS End of Life Team.

Improving care quality in response to complaints or concerns
● There was a complaints procedure in place.
● There were no complaints on file to review. However, CQC were made aware of two complaints that had not been properly documented by the previous manager.
● Most of the people and relatives we spoke with had no concerns about the service.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● The home had an activities co-ordinator who provided a range of social activities each day. They told us they had a basic schedule of activities that they facilitiated each week but the schedule was flexible. They said that at least once a month, they booked an external entertainer to visit the home.
● On the day of our inspection, we saw an activity session in progress, and people enjoying themselves. A relative told us," I went for the Christmas party and it was brilliant, the staff were getting everybody up to dance and singing and my wife loves singing".
● People told us their families and friends were always made to feel welcome.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- There was no registered manager in post. The provider told us they had dismissed the previous manager just prior to our inspection. This manager had been in post approximately 5 months. An interim manager had been appointed and therefore assisted with our inspection, along with a nurse who was a clinical lead.
- Managerial and provider oversight of the governance of the service was poor. This resulted in people being exposed to unnecessary risk and harm. Neither the previous manager or the provider had identified that people's care was unsafe and as a result no swift action to mitigate risk had been taken.
- During our visit we had serious concerns about the safety of people's care, medicines, staffing level, staff recruitment, training and support, the implementation of the MCA, the provision of person centred care, premises safety, infection control, staff and the overall management of the service.
- The quality and safety of the service was not effectively monitored to ensure risks were identified and safely managed. Where actions had been identified, these were not always addressed in a timely manner. Records in relation to people's care were not accurate, up to date or adequately maintained. This meant it was difficult to tell if people were receiving the right care and support.
- We asked the provider to submit an urgent action plan of improvements and timescales for completion. We also alerted the Local Authority to our concerns about the service. We will work with the Local Authority and the provider to ensure improvements to the service are made.

The management arrangements in place to assess, monitor and improve the safety and quality of the service was inadequate. Record keeping overall was poor. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics Working in partnership with others

- People care did not always receive person centred care, and care plans lacked adequate and accurate information about people's needs to ensure good outcomes were achieved.
- People's care records showed they did not always receive the care they needed.
- Some staff did not feel engaged or supported by the management team and provider.

The culture and management of the service was not person centred and did not ensure good outcomes for people by working effectively with others. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People and staff had access to the advice of the Advanced Nurse Practitioner from the local GP surgery for any day to day health care needs.

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

● The previous manager had not always notified CQC or the Local Authority about notifiable events that impacted on the running of the home or people's safety. Providers are required by law to submit the required notifications to CQC without delay. The information provided in notifications helps CQC to decide if further action is needed to ensure people's safety

● The provider, interim manager and clinical lead were open and transparent during our visit. They had plans in place following our inspection to address the concerns we identified.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care was not always person centred to ensure their needs and preferences were met. People's communication needs were properly identified, and people were not supported to communicate in a way they could understand.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent People's consent was not always obtained in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Safe recruitment practices were not fully followed.

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 There were not enough staff on duty at all times to meet people's needs. Staff had not received appropriate support or training to do their job role effectively.

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 12 HSCA RA Regulations 2014 Safe care and treatment The management of medication was unsafe. The provider had not ensured risks to people's health, safety and welfare were adequately assessed, and mitigated against to prevent avoidable harm. People's needs and risks were not properly assessed or managed to ensure that people's health and well-being were supported in accordance with standards and best practice. Risk of the spread of infection was not managed adequately.

The enforcement action we took:

We have issued the provider with a warning notice. This will be followed up and we will report on any action when it is complete.

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 management arrangements in place to assess, monitor and improve the safety and quality of the service was inadequate. Record keeping overall was poor. The culture and management of the service was not person centred, and did not ensure good outcomes for people by working effectively with others.

The enforcement action we took:

We have issued the provider with a warning notice. This will be followed up and we will report on any action when it is complete.