Bondcare Willington Limited

# Birch Tree Manor

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

About the service
Birch Tree Manor service is a residential care home providing personal and nursing care to 62 people. The home is a purpose built modern detached building set over two floors. The home supports people who have needs associated with ageing or are living with a dementia related illness. At the time of our inspection 62 people were living at the home.

People's experience of using this service and what we found
At our last inspection we found the service had met a wide range of concerns found at previous inspections. We did however find that there were issues with how people's capacity and consent were being managed. At this inspection we found the service provided to people had again deteriorated. Birch Tree Manor was not providing safe care for people and continued to be poorly led and managed.

People were not always protected from abuse as appropriate procedures were not always followed. Staff were not identifying potential abuse and incident reporting was poorly managed. This put people at unnecessary risk of harm.

Where people were at risk of harm insufficient action had been taken to ensure the risks were fully assessed and preventive actions understood by staff. These were both with personal risks, such as the risk of people falling, and risks in the environment.

Medicines were not always managed safely. Infection prevention and control practices were not always followed. The home was not satisfactorily clean. This meant the provider failed to ensure people were protected against the spread of infectious diseases.

The provider and registered manager did not have a clear strategy for the care of people living with dementia. Staff had not received training on how to support such people and had limited coping strategies for managing behaviours associated with dementia.

The provider and registered manager failed to implement robust governance systems to identify and address shortfalls, risks and unsafe practices.

We have made a recommendation about improving how complaints are handled.

People were not always supported to have maximum choice and control of their lives and staff did not always 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.

We have made a recommendation about helping people with limited verbal communication to express their wishes.

People told us that the staff were caring towards them.  hey told us of interesting activities and events put on by the home and how they enjoyed a range of activities led by the activities coordinator. People's relatives told us that they were always made to feel welcome at the home.

People in the home and relatives told us the registered manager was friendly and approachable.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 26 July 2018) and there was a breach relating to gaining people's consent. The provider completed an action plan after the last inspection to show what they would do and by when to improve. However, at this inspection the service had deteriorated to an overall inadequate rating. The provider was still in breach of this regulation, and we found further breaches of the regulations. The service had been rated as requires improvement for the last three inspections.

Why we inspected
This was a planned inspection based on the previous rating.

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

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 concluded.

Follow up
The provider set us an action plan immediately after the inspection to mitigate the risks.

We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 time frame and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

Inadequate

The service was not safe.

Details are in our safe findings below.

**Is the service effective?**

Requires Improvement

The service was always not 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.

# Birch Tree Manor

**Detailed findings**

## Background to this inspection

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

Inspection team
The inspection was carried out by two inspectors, an assistant inspector, a Specialist Advisor, who was a nurse practitioner, 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
Birch Tree Manor is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

Notice of inspection
The first day was unannounced and the second day was announced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with 19 people who used the service and ten relatives and friends about their experience of the care provided. We spoke with members of staff including the registered manager, four nurses, two assistant nurses, two senior care workers, five care workers, the activities coordinator and the maintenance person. We spoke with three visiting health professionals.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included eight people's care records and six people's medicine records. We looked at seven staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. The provider sent us information to show they had immediately addressed some of the shortfalls found on the inspection.

Inadequate

# Is the service safe?

## Our findings

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

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

Systems and processes to safeguard people from the risk of abuse

● People were placed at risk of harm and abuse. The registered manager had failed to effectively implement the provider's policies and procedures to keep people safe from harm, abuse and improper treatment. We found delays in reporting and inappropriate investigation by the registered manager of abuse allegations. A recent local authority safeguarding investigation had identified serious mishandling of an allegation which had compromised the investigation.

● Staff had received safeguarding training and were able to describe the signs of abuse they needed to look out for and report. However, we found a number of incidents had not been identified by staff, at all levels, as requiring a referral for investigation as potential abuse. For example, staff were not always recording and reporting bruising to people.

● Staff used restraint on some people when delivering personal care. They told us this was to ensure that people, who had limited capacity and understanding, could be supported to maintain good levels of personal hygiene. However, we found that these practices were not written up in care records and had not been subject to the principles of the MCA 2005. This meant lawful consent had not been gained and the service could not demonstrate that this was the least restrictive practice for people. Staff had not received training on restraint techniques. This placed people at risk of harm from inappropriate treatment and unlawful restraint. This was referred to the local authority safeguarding team for investigation.

This was a breach of regulation 13 (Safeguarding services users from abuse and improper treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider responded immediately after the inspection. They provided evidence that all staff had been booked onto training for managing behaviours that may be challenging and, if appropriate, for the use of restraint as a last resort. The registered manager had made sure that all staff were up to date with safeguarding training and asked the training provider to emphasise the areas of concern we had found. However, after the inspection we found that the service continued to identify and report incidents correctly.

● People we spoke with told us they felt safe with the staff who supported them.

Assessing risk, safety monitoring and management

● The provider and registered manager failed to ensure risks to people were adequately assessed, reviewed and managed.

● Assessments in place for specific risks to people did not always consider actions that could minimise the risk. For example, one person's behaviour had been identified as a risk but there was no management plans to detail potential triggers or how best to support the person when displaying this behaviour. Such plans give staff guidance on the actions they should take if a person is becoming anxious to calm and defuse a

situation. This put people and others at risk should there be an escalation.
● Staff were not carrying out full multi-factorial falls risk assessment. A multi-factorial risk assessment reviews all the factors that might contribute to a person falling and is recommended as best practice by the National Institute for Health and Clinical Excellence (NICE) when older people experience multiple falls. For example, one person known to have low blood pressure, leading to light headiness, did not have this identified in a falls support plan so staff could take extra precautions.
● The providers systems to ensure the environment was safe and well-maintained was not being effectively used within the service. We found numerous risks had not been identified, such as loose metal radiator covers, sharp corners of broken picture frames and faulty electronic keypads to cupboards that contained hazardous products.
● We found not all the actions recommended from the provider's Fire Risk Assessment in April 2019 had been actioned, some stated as immediate, such as to remove the garden incinerator. The timescales for fire safety training updates were unclear.

We found a failure to adequately assess, monitor and mitigated risk meant people were being exposed to the risk of avoidable harm. This was a breach of regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager ensured checks of the fire safety systems were conducted weekly. The provider had contracts with external companies for the safety of the equipment used in the home, such as moving and handling equipment, and for testing gas and electrical devices.

Preventing and controlling infection
● People were placed at risk of cross infection. The service was not applying good infection control measures to ensure the home was clean and the risk of cross infection minimised.
● Staff did not have protective personal equipment (PPE) readily available when carrying out personal care. We saw that in all the bathrooms and toilets there were no PPE available. This equipment was stored in linen and other multi-use cupboards. We found these cupboards to be disorganised, messy and dusty. Some of the PPE, such as gloves and aprons, had fallen on the floor. The registered manager took action during the inspection and ordered units to hold PPE within the bathrooms and toilets.

● The registered manager 'walk around' to check on standards had not ensured that all areas of the home were clean. For example, we found the fridges in each of the units were not clean, with food spillages and unlabelled and undated opened foods. In the bathrooms we found that two baths were dusty and had not been cleaned for some time, and next to one toilet was stored a toothbrush in a vase.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate effective infection control. This placed people at risk of harm. This is a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● The provider's systems for recording and monitoring accidents and incidents were not being used effectively by the service to mitigate risk. For example, the home's Falls Risk log and not been used to identify any patterns with people and this meant opportunities to reduce falls may have been missed.
● The registered manager told us that they were checking that call bells were responded to in a timely manner but not to analyse for trends. Family members told us that most of the falls experienced by their relatives were at the weekend.

● All incidents for the past 12 months had been either recorded as 'requiring no further investigation' or had been left blank as to whether further investigation was required.

The failure to assess, monitor and improve the service meant people were put at risk of harm. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Staffing levels did not always meet people's needs.

● The provider had a system to check staffing levels were sufficient to meet the needs of the people in the home. The registered manager told us the home had not completed this dependency tool for sometime.

● While we judged the number of staff were sufficient the deployment of staff was not always carried out in an organised way. This meant that at times people were left unsupervised or had only some of their needs partly met before staff moved on to assist other people. Some people told us they had to wait for support when they used their call bell.

Staff were not being effectively deployed to meet the needs of the people in the home. This meant people were not getting their needs met in a timely manner. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service had a system in place to help ensure staff were of suitable character to work with vulnerable adults. All staff had a police and identification checks before working at the service.

Using medicines safely

● Medicines were not always managed safely. The registered manager had failed to ensure that there were clear protocols in place to guide staff about when and how to administer 'as required' (PRN) medicines, in accordance with NICE guidance. Some people were prescribed sedatives to calm them when they became "agitated". However, written guidance was not in place as to when the person should be offered the medicine, how it should be used and action to take if it was not effective.

● We found that people's allergies were not always clearly recorded and this placed people at risk.

The provider had failed to ensure systems to manage medicines safely were followed by staff in the service. This was a breach of regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

# Is the service effective?

## Our findings

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

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

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

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

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

At our last inspection the provider had failed to ensure people's consent was effectively sought and capacity was not being assessed in accordance with the Mental Capacity Act 2005. Not enough improvement had been made at this inspection. There was evidence of a continuing breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The service was not meeting the requirements of the MCA 2015. People's capacity was still not recorded clearly and consistently in people's care files. The care plans contained no detail of the types of decisions people could make or communication support needs having been considered when making best interest decisions.
- People were subject to restrictive practices that had not been subject to a best interest meeting or contained within a DoLS authorisation.
- Relatives were making decisions on people's behalf and it was unclear whether they had authority to do so as this was not recorded, such a lasting power of attorney.
- The registered manager had started to use a DoLS monitoring tracker sheet since the last inspection. However, this was not updated in people's care files so that it looked like some people's DoLS had expired when they had not. When we asked a nurse on duty they said they didn't know if one person's had expired or not. This is a concern that this level of staff did not know the status as it is the duty of all staff to apply the

restrictions of DoLS orders to ensure people are safe.
● We did see assessments and consent for the use of bedrails were in place. These had been done in a good amount of detail and each step of the decision-making was clearly set out.

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 had not been adequately assessed and recorded. Some information in care plans was contradictory or missing. For example, one person who was diabetic had not been assessed for pressure care or foot care. These are both high risk factors for people with diabetes and are indicated in the NICE guidelines for the management of diabetes and associated long-term health complications.
● The registered manager stated people's needs were reviewed monthly. However, we noted some significant changes to people's health had been reviewed, such as an increase in falls, with a statement of 'no change' recorded in their care plans. These people continued to fall and sustain injuries with no reassessments taking place.
● Assessments of how to manage people's pain was either not recorded or plans did not state how people would express pain if they were unable to verbalise this.
● Guidance and assessments from external professionals, such as the Speech and Language Therapy (SALT) team and the Falls team were not clearly incorporated into people's care plans.

The systems for assessing people's needs and treatments was not robust. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. The provider was in breach of Regulation 9 (Person-centred care) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People and their relatives told us that they were well supported with their healthcare. One person told us, "They get the GP for me if he's needed." One person's relative said, "If there is anything wrong health wise, it gets sorted quickly with the doctors."

Staff support: induction, training, skills and experience
● The registered manager had not ensured staff received training appropriate to their roles. Some people living with dementia needed support when they felt distressed and staff responded inconsistently. Staff had only received a basic dementia awareness session that was part of their induction training day. None of the staff had training on managing challenging behaviours and the appropriate use of restraint.
● Staff were not aware of relevant good practice guidance and ways of responding to people. We found the dementia unit was chaotic, people had little to do and were unsettled. There were no champion roles in the home for dementia care to promote and share good practice of the latest guidelines.
● The provider and registered manager had not ensured that all staff were up to date with mandatory training. For example, training for moving and positioning people had been completed for 88% of staff and the timescales for fire safety training updates were unclear.

People were put at risk as staff were not appropriately skilled, trained and competent to carry out their roles effectively. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately after the inspection by arranging for all staff to have more in-depth dementia care training that included the appropriate use of restraint.

● Staff were receiving regular supervision with their line manager that included work practices, training needs and details of staff areas for improvement.
● All staff completed an induction training programme before working in the home and had refresher updates periodically.

Supporting people to eat and drink enough to maintain a balanced diet
● The provider failed to ensure people's nutritional needs were managed safely. Where people were at risk of choking or had swallowing issues there was a lack of guidance for staff. We found one person was recommended to have fork mashable food however this was not always provided putting the person at increased risk of choking.
● The NHS SALT team visiting the home expressed concerns about staff in the home not using the new national guidance descriptions for the different stages of food and drinks for those people at risk of choking. The national deadline date for full implementation was April 2019 with a 12 month lead up put action in place. People's care records had not been updated using the new guidelines. While the registered manager informed us that she had been in contact with the SALT team to source training this had not taken place. She said posters were displayed around the home on the new descriptors.
● We found there was a lack of monitoring of people's fluid intake. Fluid charts were not always completed consistently and accurately and did not state the minimum amount people should have to drink.
● People had an inconsistent mealtime experience depending on which unit they were on. Some interaction were very positive and staff sat with people who required support for the duration of their meal. However, other people were left part way through their meal and this went cold. On one unit people were not positioned correctly for eating and drinking. Some people were slumped in chairs while others remained wheelchairs.
● Staff had not ensured people's mealtimes and snacks were evenly spaced out. We saw cake and biscuits being offered to people 20 minutes before the main meal of the day. Some people then struggled to finish their main meal which was of better nutritional value than the snack.

The provider's failure to manage people's nutritional needs safely demonstrated a breach of Regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us that they enjoyed the food provided at the home and there was a good variety. One person told us, "The food is lovely." One person's relative said, "The food is very good, they always ask her what she wants." Relatives told us staff acted when people lost weight. For example, a family member said, "[My relative] lost a lot of weight, but the home got it sorted with the GP and she now has supplements and her weight has stabilised."
● The kitchen staff were aware of people's special dietary requirements and any allergies people may have and catered for these; they worked with senior care staff to obtain this information.

Adapting service, design, decoration to meet people's needs
● Adaptations had been made to the environment to make it supportive of the people who lived there, some of whom were living with cognitive impairment. For example, handrails were painted in contrasting colours to make them more visible.
● Signage had been provided to help people find toilets and bathrooms, the doors of which had also been painted a bright colour to make them stand out.
● The gardens consisted of a large lawn areas which people said they could use if they wished. One relative told us, "The gardens are lovely they're safe, which means everything."

Requires Improvement

# Is the service caring?

## Our findings

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

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

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

- People were involved in planning their care and the day to day support they received. Their views were recorded in pre-admission assessments and in their care plans. One person told us, "I remember filling in my care plan, the nurse sat down with me and asked how I like things done." Another person told us, "I can say when I want it updating." A relative told us, "Yes, we went through the care plan, it covered a lot even to what biscuits he likes and what he likes to be called."
- Staff knew people and their life histories well and used this information to engage positively with people.
- We received mixed views on family members being kept up to date with any changes to their relative's needs. A family member told us, "I like it that they [staff] contact us by phone whenever there's as issue, so the family know what's happening." Other relatives reported not being informed when their relative had had a fall.
- People were given the opportunity to express their views on an on-going basis with staff and during 'residents meetings'. A relative also told us, "We get a questionnaire every six months we post it back in checking whether we are satisfied or not."
- For people with limited verbal communication or problems with understanding we found the home had not explored other ways to enable them to express their views. Such as communication boards, easy read pictures or the use of IT touch pads. We have addressed this in the responsive section of the report.

Respecting and promoting people's privacy, dignity and independence

- People's privacy was protected while personal care was being delivered. Staff described the practical steps to ensure people's dignity was upheld. However, some people told us of delays in receiving personal care. One person told us they often had to wait to go to the bathroom.
- People's confidential notes and records were not being stored securely. We found piles of records waiting to be archived in public areas, and computer screens were left open with people's private notes visible. We reported this to the registered a manager who arranged for these issues to be addressed.
- We saw examples of staff promoting people's independence where possible. One person told us, "I like to walk and I don't like sitting around, the staff let me do this." Another person told us, "The staff help me to make choices. They hold the clothes up for me to decide what I want put on."

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

- People and relatives told us they had positive relationships with staff. One person told us, "I like the carers; they do look after us well." Another person told us, "The staff know me well and bring me the biscuits I like, bourbons." A family member said, "The staff are very kind and patient." "I've got no problems with staff, they

treat [my relative] lovely."

● The interactions we observed between people and staff were mostly positive, polite and respectful.

● Staff showed concern for people's comfort and repeatedly checked whether people needed cushions or extra clothing. Staff demonstrated other considerate touches, such as organising a valentines meal for everyone in the home, with a special menu, flowers and cards. Another person had missed a theatre trip due to ill health and staff arranged to take them when they were better.

● Relatives told us they were made welcome. One relative said, "The family are so grateful [person] is now settled."

● Most people's care plans included information about their background, lifestyle choices, important relationships and circles of support.

● Staff had equality and diversity training. Staff recognised people's diverse needs and policies were in place that highlighted the importance of treating people as individuals.

Requires Improvement

# Is the service responsive?

## Our findings

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

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

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

- The lack of information in people's care records put people at risk of receiving inappropriate or inconsistent care.
- People had a care plan detailing their needs, wishes and preferences. However, we found care plans did not always contain enough information to support staff to provide personalised care in a consistent way. For example, one person's care plan had no background information on the person and contained no information about their mental health history.
- The care plan for supporting a person when they acted in a way that put themselves and others at risk was not robust; it did not provide advice about when or how staff should support the person and when a sedative should be offered. Although some 'behaviour logs' had been completed, there was no guidance about when and how these should be used.
- People's end of life plans were mainly professional information relating to emergency health care plans and did not reflect what the person's wishes were.
- A healthcare professional expressed concerns about the way staff recorded information. They said, "I sometimes have issues with their documentation. For example, I suggest things and they are not always passed over [from one staff member to the next]. Things may happen for a couple of days but then don't continue."

The provider had failed to ensure the care and treatment of people met their needs and reflected their preferences. This was a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People told us they could make choices in relation to their day to day lives; for example, what time they liked to get up or go to bed, what they ate and where they spent their time in the home. We observed choice being offered throughout the inspection.
- People's relatives told us that they were involved in people's assessments and putting together people's care plans.

Meeting people's communication needs

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

- Some information was provided to people in a variety of formats, for example, the complaints procedure

was available in an easy read format.
● The registered manager told us that information would be sourced on an individual basis for people as they needed it in line with their needs. They told us told us flash cards were available for staff to use with people. However, we found in practice there was little in the way of adapted material or the use of technology to help non-verbal people to express themselves.

We recommend the provider consider current guidance and seek guidance from a reputable source to aid people's communication and take action to update their practice accordingly.

Improving care quality in response to complaints or concerns
● There was information available to people about how to make a complaint if they were unhappy with the service.
● The registered manager kept a record of formal complaints and how these had been investigated and actioned. These adhered to the providers' procedures and timescales.
● At this time minor complaints and verbal complaints were not being recorded to demonstrate these were taken seriously and acted upon. One relative told us about a verbal complaint they had raised with the registered manager. While they said it had been had been sorted out they also commented, "It can be a lack of communication and I would like to see steps put in so it doesn't slip through the net again and to tell me why." This meant opportunities to give feedback and learn from these types of complaints were being missed.

We recommend the provider seek guidance from a reputable source to improve how they capture compliant and use these to drive up the quality of 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 provided a good range of activities and entertainment. People and their relatives spoke positively about this and commented, "The activity co-ordinator is so enthusiastic, she always has something going on, it's absolutely great" and other person told us, ''It's excellent entertainment."
● The activities co-ordinator arranged visits from community including pet therapy, church services and from local school children. They also worked with a local committee of interfaith churches to support people at the home to express their faith by visiting churches of different denominations and having local clergy visit the home.

Inadequate

# Is the service well-led?

## Our findings

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

At the last inspection this key question was rated as requires improvement . At this inspection this key question has deteriorated 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

- The provider and registered manager failed to implement robust governance systems to identify and address shortfalls, risks and unsafe practices. Where people were at risk of harm insufficient action had been taken to ensure the risks were fully assessed and preventive actions understood by staff. These were both with personal risks for individuals and risks in the environment.
- Provider audits had not identified a number of serious risks within the building. The registered manager told us many of the checks they made were visual and sorted out as they did 'managers walk around'. There were limited recordings to show audits and actions had taken place. For example, a lock on a cupboard door containing toiletries within the dementia unit had been faulty for sometime. We saw this door open on numerous occasions and asked staff to ensure it was locked. A relative told us, "There was an incident and for the safety of the residents all toiletries are now locked in a store cupboard."
- The registered manager had failed to meet the requirements of the fire risk assessment within the agreed timescales. This meant people would be at risk of harm if there was a fire. We contacted the fire service to notify them of our concerns.
- Record keeping was poor across the service. Documentation relating to people's care and support was not complete. The registered manager's audits had failed to identify this.

Due to poor governance of the service people were put at risk of harm. The provider failed to assess, monitor and mitigate risks to people and others. Accurate, up to date records were not kept for each person using the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager failed to demonstrate skills and competency to manage the service well for people. They had compromised a safeguarding investigation and demonstrated a lack of knowledge about the care of people living with dementia. Potentially unsafe and inappropriate care had gone unchallenged within the home. For example, by not identifying how the use of restraint to deliver personal care to people should be properly managed.
- Since the registered manager had been in post the home had been rated as requires improvement three times and on this inspection there were multiply breaches found with an inadequate rating.

People were put at risk of harm as the registered manager did not demonstrate they had the required skills and competency to manage the service effectively and safely. This was a breach of Regulation 7

(Requirements relating to registered managers) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care

● The provider failed to ensure issues highlighted in previous inspections were addressed, such as gaining consent from people and meeting the requirements of the MCA 2015.

● Actions from external audits had not always been acted upon. For example, the falls risk assessment audits did not demonstrate how these were used to identify patterns and trends. And the call bell monitoring system was not used to identify the effectiveness of response times.

● There was no evidence that the registered manager gathered and used information in the day to day delivery of the service such as care plan reviews, resident meetings, safeguarding incidents, accident and incident data to learn and improve the care provided to people.

● Systems and processes to assess risk and monitor quality were insufficient and ineffective in driving improvements. The registered manager was unable to demonstrate a commitment to continual improvement and was not keeping up to date with current best practice guidance.

The provider failed to assess, monitor and improve the quality and safety of the service provided. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● A review of accidents and incidents at the service revealed there had been no incidents that met the threshold to trigger the duty of candour requirements. However, when we discussed duty of candour with the home manager, they did not demonstrate a clear understanding of the requirements. Some relatives told us they had not been informed when an accident had occurred with their relative.

● The provider's policy was clear about how and when the requirements should be met. However, the registered manager acknowledged this was an area they needed to research further.

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

● People were not always given person-centred care as their records were not complete or up to date.

● However, the service sought feedback from people during 'residents meetings' and in one-to-one discussions with people. Staff meetings were held and staff said these were open forums to express their views and opinions on the day-to-day running of the service.

● Relatives told us they could visit at any time and were always made welcome. One relative said of the staff, "They are good with us and we're always offered a drink. And can come at anytime."

Working in partnership with others

● There was evidence of the service making referrals and working in partnership with some other agencies. The home had a close working relationship with GPs, who held a weekly surgery at the home and they frequently made use of the Tele-triage servcie to seek advice.

● However, a number of professionals expressed their concerns about the management of the service. They told us they felt that there were sometimes delays in seeking their advice and this was then not always communicated to other staff or written up into care plans.

● We were told by some relatives the service worked in partnership with other agencies to manage people's needs. One relative told us, "They [the service] organise the opticians, dentist, and chiropody."

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care |
| Treatment of disease, disorder or injury | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>People were not receiving person-centred care and treatment. Care plans were not up to date and did not detail how people's holistic needs were to be met.<br><br>Regulation 9(1)(2)(3)(b)(g) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent |
| Treatment of disease, disorder or injury | Regulation 11 HSCA RA Regulations 2014 Safe care and treatment Need for consent<br><br>The provider failed to ensure people's consent was lawfully gained and the MCA 2015 was complied with.<br><br>Regulation 11(1) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment |
| Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment |

The provider failed to ensure robust systems were in place to assess, monitor and mitigated risk. This included ensuring that medicines were managed safely. This placed people at risk of harm.

Regulation 12(1)(a)(b)(2)(g)

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 7 HSCA RA Regulations 2014 Requirements relating to registered managers<br><br>Regulation 7 HSCA RA Regulations 2014 Requirements relating to the registered manager<br><br>The provider had not ensured that the registered manger was appropriately skilled with the qualifications, knowledge, experience and competency required to manage the regulated activity.<br><br>7(1)(2)(b) |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>People were not being supported by suitably qualified, supervised and skilled staff. Staff were not being deployed to meet people's needs and to ensure their safety.<br><br>Regulation 18(1)(2)(a) |