J D Singh

Belvedere Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We inspected this service on 8, 9 and 14 November 2018. The inspection was unannounced.

Belvedere Residential Home is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service provides accommodation and personal care for up to 19 older people and accommodation is located over two floors. There were 16 people living at the service at the time of our inspection. A number of people there lived with dementia.

The provider has a history of non-compliance of Regulations. During our last inspection on 30 April and 01 May 2018 we found there were four breaches in the legal requirements and Regulations associated with the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014. These related to the care and treatment people received, systems to employ fit and proper persons, person centred care and quality monitoring of the service. We gave the home an overall rating of 'Requires Improvement'. This was a repeated rating from the previous two inspections to the home.

Following that inspection, we met with the provider and registered manager who gave us assurances that actions would be taken to bring about improvement. This was reflected within an action plan.

However, at this inspection we found the service had not sufficiently improved and the quality and safety of service people received had deteriorated further. We identified six breaches of Regulations including a continued breach in relation to quality and safety monitoring.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not, enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

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

varying the terms of their registration.

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.

We have met with the provider to discuss the significant concerns identified at this inspection. We, and the provider, are liaising closely with the Local Authority to ensure people's safety.

There was a registered manager in post who had worked at the home for over 18 years. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found systems and processes to monitor the quality and safety of care and services were inadequate. This placed people at significant risk of harm. Areas needing improvement were not always identified and acted upon. People did not feel involved in contributing to decisions made about how the home was run.

People did not always receive safe care that met their needs because risks were not always identified and managed. People's care plans continued to need improvement, so they were centred on the person and contained sufficient information for staff to recognise and manage risks. Staff were not always able to work in accordance with people's needs and preferences due to environmental restrictions such as limited access to baths and shower rooms.
Health and safety checks were ineffective. We identified a number of potential risks which had not been assessed by the provider to ensure people were kept as safe as possible.

Accidents and incidents were not always recorded, and action was not always taken to minimise the risks of a re-occurrence.

People's medicines continued not to be managed and administered safely to maintain people's health. We could not be confident some medicines had been administered as prescribed.

Staff had completed some training to support them in meeting people's needs. However, we identified some poor staff practices and staff competencies had not been checked.

Improvements to the staff recruitment system had been made which minimised potential risks to people. Staff understood their responsibilities to protect people from harm. Staff were encouraged and supported to raise concerns under the provider's safeguarding and whistleblowing policies. However, they did not feel their concerns were always acted upon.

People liked the food available and said they had a choice of meals. Risks related to people's nutritional needs were not always identified and action was not always taken to minimise risks.

Some social activities were provided at the home and some people enjoyed these. People had limited opportunities to access activities outside of the home.

Overall, people were mostly positive about the staff that supported them. We saw staff were caring in their approach. People's privacy, dignity continued not to be maintained consistently. People were able to make

some decisions about their care but were not involved in ongoing reviews of their care. When care and support was delivered that restricted people's liberty, some applications had been made to the supervisory body for the authority to do so.

People had access to healthcare professionals although this was not always sought in a timely manner.

We identified six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks related to people's care and the environment were not always identified or managed to keep people safe. Staff understood how to identify potential abuse but concerns they identified were not always investigated and managed to keep people safe. Medicines were not always managed safely to ensure people received their medicines as required. People felt enough staff were available to meet their needs. Recruitment checks were made before new staff worked at the home.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were asked for their consent before staff provided care. Staff had limited understanding of the Mental Capacity Act. Deprivation of Liberty Safeguards applications had been submitted for most people as required. Staff training was not always effective. Not all staff had completed essential training. People enjoyed the food and were provided with a choice but their nutritional needs were not always met. People had access to healthcare professionals although this was not always in a timely manner.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were mostly positive about the staff. Staff were caring and respectful in their approach to people. People's privacy and dignity was not always maintained.

Is the service responsive?

Inadequate

The service was not responsive.

People did not always experience care in accordance with their preferences. People's care plans did not always contain sufficient detail to support staff in delivering care in accordance with people's needs. Staff knew people well and had some

understanding of how to respond to their physical needs and temperament.

Is the service well-led?

Inadequate

The service was not well-led.

Processes and systems to check the quality of the service were either not in place or were ineffective. Audits and checks were not adequate to ensure the premises and equipment were safe for people. Staff and people were not given opportunities to be involved in decisions about the home.

Belvedere Residential Home

Detailed findings

Background to this inspection

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

The inspection was undertaken in response to information of concern which indicated that people were not kept safe. This information is subject to a safeguarding investigation, and as a result, this inspection did not examine the specific circumstances relating to the concerns.

Information shared with the CQC indicated potential concerns about the management of risk in relation to injuries people obtained at the service. This inspection examined those risks. Where appropriate, information was shared with the Local Authority and Police for them to investigate issues further.

At the time of our inspection, areas of immediate risk were brought to the attention of the provider to enable them to take the necessary action to keep people safe.

The inspection took place on 6, 8 and 14 November 2018 and was unannounced. The inspection was undertaken by two inspectors.

As part of planning the inspection, we reviewed information we held about the service. We looked at information received from Local Authority commissioners and the statutory notifications the registered manager had sent us. A statutory notification is information about important events, which the provider is required to send to us by law. These can include unexpected deaths and injuries that occurred when people received care. Commissioners are people who work to find appropriate care and support services, which are paid for by the local authority.

During our inspection visit we spoke with eight people about their experiences of the home. We also spoke with six staff, including a cook and a cleaner about working at the home. We spoke with the registered manager and the deputy manager about their management of the service. Some people who lived at the service were not able to tell us in detail, about how they were cared for. We observed care and support being delivered in communal areas and we observed how people were supported at lunchtime.

We looked at information in six people's care plans and other care records related to people's care, to see how care and treatment was planned and delivered. We looked at records related to staff recruitment, staff training, medicines, accidents and incident records, and records used for quality monitoring to see if actions to improve the service were identified and acted upon.

Inadequate

Is the service safe?

Our findings

During our previous two inspections, we found improvements were needed to manage risks associated with people's care to keep them safe. During this inspection, we found improvements were still needed. We also found additional areas of significant risk which meant people were not safe and have therefore rated this key question 'Inadequate'.

People did not always feel safe living at the home. One person told us, and their care plan confirmed, they required assistance from two staff members to assist them with their personal care. However, the person explained on occasions they were assisted by one staff member only. They said, "It should be two (staff) but when [staff member] is on they change me on their own.... I'm not sure it's safe but it's the way it is here." Another person told us. "They (staff) lift me up under my arms."

We observed on one occasion three care staff were unable to use a hoist to move a person safely. They needed the assistance of a member of the management team to identify and resolve the problem. The registered manager was aware that other staff had also reported that the hoist did not work properly. However, when they had checked, they identified staff had failed to release a button on the hoist so they could use it. We were concerned because this demonstrated staff did not always know how to use equipment safely. Moving people safely was an issue we had been identified at our previous two inspections of the home. Insufficient action had been taken to address this which meant both staff and people were placed at risk of injury. Owing to the risks of unsafe moving and handling we asked the registered manager to bring forward the date of staff training in moving and handling people to reduce the risk of people receiving unsafe care and support.

Toilets people used continued to be very small with limited space for people to be supported safely. Because of the limited space we observed a staff member had to remove a person's walking frame from them so the person could get through the door to a toilet. This meant the person had to walk into the toilet without their walking frame which placed the person at risk of falling.

During our previous inspections we found improvements were required in identifying people's changing needs and abilities and in updating people's risk assessments and care plans. During this inspection, we found this continued to be an area needing improvement.

Prior to people living at the home, an assessment of their needs was completed to ensure their needs and any risks associated with their care could be planned for and managed. However, changes in people's care were not always identified in their records and new risks were not always managed. For example, one person had lost 5kg of weight between February and October 2018. A nutritional risk assessment had been completed and stated the person should be offered three fortified meals (calories added to food) and two nourishing snacks per day. This was to reduce the risk of further weight loss and to maintain their health. However, the provider could not demonstrate this always happened. Staff had completed food charts for the person, but these records did not show foods had been fortified or that snacks had always been provided. Whilst staff told us snacks such as yoghurts, fruit and biscuits were made available to people we

only saw biscuits were provided as 'snacks'.

Staff did not always follow risk assessments effectively to keep people as safe as possible. For example, one person was at risk of choking when eating and drinking. This risk had been assessed and instructions in their risk assessment to manage this risk stated, 'A member of staff to observe [Person] during mealtimes.' However, we saw this did not happen. The person was coughing at lunchtime in the dining room and no staff were present. The person coughed for several minutes and we saw their eyes started to water as they struggled to catch their breath. We offered the person reassurance until a staff member came shortly after to assist. We checked the person's nutritional records and these stated, the person required a prescribed thickening agent added to their drinks. Records did not state how much thickener to add but stated the drink must be of the consistency to 'coat the back of a spoon'. This was to ensure their safety. When we checked the person's drink it was not of this consistency. We noted their nutritional risk assessment also stated, 'food to be cut up into small pieces' but 'small' was not defined. We saw meat on the person's plate had been cut up but not into small pieces. Therefore, the risk of this person choking were not sufficiently managed to keep the person safe. We brought this to the attention of the registered manager who told us they would make contact with the speech and language therapist.

We saw three people's walking frames in use which were unsafe to use because the grip on the rubber feet had worn away. We brought this to the attention of the registered manager who made arrangements for them to be changed.

We also noted that call bells were not always accessible to people with the ability to use them so they could summon staff for assistance when they needed it. One person we found was anxious because they needed the toilet and had been unable to make staff aware of this.

During previous inspections we found improvements were needed to ensure people were kept safe in the event of a fire. One of these risks was for the provider to review the practice of propping people's doors open with door wedges as this placed people at risk in the event of a fire. They had assured us that door closures would be fitted to the doors of those people who wished to keep them open, however, this had not happened. We saw bedroom doors continued to be propped open. There was no risk assessment to show how this risk was being managed. We asked the provider to submit a risk assessment to us to ensure this risk was managed until door closures were fitted, and this was provided.

Staff told us they did not feel people were safe. One staff member told us, "No, I don't think it's safe here. I wouldn't let my relative live in here. There is not enough of us to keep a proper eye on people. At night there is only two staff I don't know how they manage. If there was a fire with just two staff on it's a real risk." Staff told us they did not have practice fire drills. One said, "We don't have fire drills, no. We had one after your last inspection and then we were told they would happen monthly. We haven't had any more." Another said, "I can't remember taking part in any, not where we actually evacuate." This meant staff were not given the opportunity to practice and be clear on their responsibilities in the event of a fire.

People had personal emergency evacuation plans in place for staff to follow. However, staff told us the actions were not realistic. This was because the plans advised them to evacuate everyone from the building and they would not be able to do this safely. They told us there would not be enough staff on duty at night to evacuate everybody and they would not be able to use the new fire sledge for one person as they didn't feel it was safe for them to use for the person concerned. We raised these issues with the provider and advised them to take urgent action to address them. We also made the fire service aware of the concerns we had identified.

People's medicines were not managed safely or consistently. We saw one person had a glass of water with a tablet left in the glass. The person was of the understanding the tablet was dispersible in water, but we saw it was not. The registered manager was also of the opinion it was dispersible. Staff had not observed the person to take their medicine in accordance with safe and good practice. We also noted from medicine records that there were several people who had creams prescribed however records did not confirm they had been applied. It was, therefore not clear if creams had been applied at the required times or not.

During our last inspection we had found creams in people's rooms that did not belong to them. At this inspection, although we did not find this issue, there were creams in use where labels had worn off and it was not clear which person they had been prescribed for. The date some creams had been opened had not been recorded. Therefore, it was unclear they were being used within the recommended timescales. We advised the registered manager of this concern so they could address it.

We considered how effective the management of infection control was in the home. We saw staff used gloves and sometimes used aprons when supporting people to help prevent the spread of infection. We noted there was a sign for staff to put on aprons when entering the kitchen, but this instruction was often ignored. We saw laundry baskets on two occasions overflowing with soiled linen and a bedroom with thick dust that had not been cleaned effectively. The registered manager told us cleaning schedules were not in place to demonstrate all areas of the home were cleaned regularly. On one of the days we visited, a domestic assistant was not on duty at the home as they had phoned in 'sick'. We asked a staff member who would complete the domestic duties and they told us "No one." We discussed this with the registered manager and they explained that the care workers and the laundry assistant would "do a bit of cleaning" if they had time.' We asked if they had tried to arrange cover and they told us they had not.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe Care and Treatment

Staff completed body charts when people had injuries or bruises, but we noted six of these charts did not record the likely cause of these injuries and bruises with three stating the cause was "unknown". The registered manager told us they were not aware of these injuries and therefore had not investigated the potential causes, or shared the information with the Local Authority. This meant no action had been taken to investigate or minimise the risk of further bruises or injuries to keep people safe. On 8 November 2018, the registered manager told us they would implement a form for staff to complete when they identified injuries or bruises. However, when we visited on 14 November 2018 we found staff were not consistently using this from. For example, since the implementation of the new form, we saw on a person' body chart they had unexplained bruising. This information had not been recorded on the new form and therefore not followed up. The new process was not effective as risks to people's health and welfare were not minimised.

Staff told us they understood their responsibilities to protect people from harm. Staff knew to report potential abuse but were not confident their concerns would be dealt with to keep people safe. One staff member told us, "I have raised issues with [Registered Manager] when I've found bruises on people. I did a body map, but I don't know if things get reported to social workers. We're not given any feedback." Another told us, "I have had safeguarding training. I know what abuse is. I've reported things when I have been worried, but nothing really gets done."

We looked at the 'communication book' which the staff team used to share information about people. We saw a staff member had written an entry in October 2018 that stated one person had a swollen hand and the cause was "unknown". We asked the registered manager what action they had taken to investigate this unexplained injury. They said, "I don't know anything about it. I haven't done anything." This further

demonstrated the registered manager had failed in their duty to keep people safe.

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

Following the last inspection, action had been taken to ensure risks associated with staff recruitment were identified and acted upon. The registered manager had undertaken risk assessments where needed and recruitment practices minimised risks to people's safety. Prior to staff working at the home, the provider checked their suitability by contacting their previous employers and obtained Disclosure and Barring Service (DBS) checks. Staff told us they had to wait for DBS checks and references to come through before they started working in the home. The DBS is a national agency that keeps records of criminal convictions.

Following our inspection, we asked the provider to immediately address the significant risks we had identified related to people's safety. The provider confirmed they would address them and we checked this had happened.

Requires Improvement

Is the service effective?

Our findings

During our previous two inspections, we found improvements were needed to ensure the service was effective and this key question was rated as 'Requires Improvement'. During this inspection we found improvements were still required. Therefore, effective continues to be rated 'Requires Improvement'.

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 make 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. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

Staff understood the need to obtain consent from people when delivering care and we saw this happened. Staff told us they had some understanding of the MCA and DoLS, however, they were unable to tell us if anyone living within the service had a DoLS in place. One said, "I haven't a clue, you need to ask the managers." When we discussed this with the registered manager they were not clear about who had a DoLS in place. They advised us this information was usually managed by the administrator who was not available at the time of our visit. We found written records and computer records held at the home in relation to DoLS did not correspond. Therefore, the provider was unable to demonstrate applications had been made.

People lived in an environment that was not always suitable for their needs. For example, some people were unable to access the bathing or showering facilities in line with their wishes. One person told us they would like to 'have a soak in the bath' but because they were unable to use the stairs or the stairlift to gain access to the bathroom, they could not have one. Staff told us another person would like to have a shower, but they could not have one as they were unable to get down the flight of stairs to the shower room. Another staff member told us, "People's choice is taken away here because the bathrooms are too small people have to have bed baths."

The premises were not designed for people who lived with dementia. There was a lack of reminiscence areas, memorabilia or adaptions to the environment. Sensory stimulation can improve thinking skills and help people to maintain an interest in their environment.

Staff told us no hot water had been available at the service during the morning of one of our visits. One staff member told us, "With no hot water this morning, it took longer to get everyone washed. No one had to wait for help, but we had to go to get bowls of warm water from the kitchen which meant we were back and forth. It does happen quite a lot but usually someone comes out the same day to fix it." Another staff member told us, "We don't have hot water in every room in the morning because the system does not work, the owner was supposed to sort that."

People felt some staff had the skills and knowledge to care for them effectively but during our inspection visits we identified concerns linked to staff training. The provider could not demonstrate that essential staff training was up-to-date or that staff competencies had been checked. For example, with regards to fire training, staff we spoke with gave differing accounts of the action they would take in the event of a fire. One said, "We get people out of the front door." Another told us, "We go to the carpark at the back through the lounge."

Two people who lived at the home had mental health care needs. Staff told us they had not completed training to support those people. One staff member told us, "I haven't a clue what to look for to indicate they are unwell." The registered manager told us they were unable to meet the needs of one of these people and had advised health professionals of this.

Our observations of staff moving and handling practice demonstrated a need for further training. On our advice, the registered manager confirmed the training had been brought forward for the week following our inspection visit.

All staff we spoke with told us they had not received one to one meetings with their line manager recently. One staff member told us, "We did have (supervision meetings) but not for ages." Another said, "We don't have spot checks or observations. No one really checks we do things right, we are kind of just left to get on with it." They told us this made them feel unsupported by their managers.

The registered manager told us they had "fallen behind" with observations and supervisions of staff due to being absent from the home for a six-week period. They told us this was something they needed to address.

People told us they had sufficient amounts to eat and drink and were provided with a choice of meals each day. Comments included, "I like the food, its tasty," and, "I like it." We saw the cook asked people what they wanted to eat for their meals each day. However, staff were not able to confirm people were involved in deciding what was added to menus. One person told us, "I've never been asked if I would like anything added (to the menu)." A staff member told us, "People are not really asked, well I don't think they are." However, staff knew what people liked to eat and drink.

We saw people were offered a choice of hot and cold drinks and some people had adapted beakers which they used to drink independently. The cook told us they were able to meet people's cultural needs and preferences as required.

At lunchtime, staff collected people's meals from the kitchen where the cook had plated them. People were encouraged to sit in their friendship groups and were offered the choice of cold drink. Some people chose to eat their meals in their rooms and we saw people in their rooms had drinks available to them.

Records showed people accessed healthcare professionals such as opticians, dentists, chiropodists and GPs. However, we had identified some health care issues which staff had not followed up in a timely way. For example, one person had been prescribed a medicine for an ongoing health problem that caused them some discomfort. A lack of communication with a health professional had delayed the treatment which had caused the person prolonged discomfort.

Requires Improvement

Is the service caring?

Our findings

At this inspection, we found people were mostly as content living at the service as they had been during our previous inspection. However, people's privacy and dignity continued to be compromised. This key question is therefore rated 'Requires Improvement'.

Staff told us people's dignity was not always respected. One staff member said, "[Person] wasn't comfortable with men washing them at first, but they have had to get used to it. I don't think it would have been their choice, as it's not very dignified for them but they accept it now. It's difficult to maintain dignity here, especially in the shared rooms as the curtains don't pull all the way across. People can see each other when they are on the commode. I don't think that's good." We had raised the issue of the curtains in double rooms not being sufficient to maintain dignity during our last inspection. Whilst the curtains had been made longer they did not extend to the width of the room and continued to compromise people's dignity.

Due to the limited space in the toilets staff were unable to maintain people's dignity. One staff member told us when they were assisting someone in the toilet, "I can't close the door after me it's too small." They went on to tell us they had to remove a person's underclothes with the toilet door open and said, "When I go in, it's too small I have to leave the door open."

We saw people's independence was not always respected. A staff member explained how one person had told them they would like a bath but because they were unable to get the person upstairs the person had to have a "bed bath". They told us, "It's taking their independence away a bit because if we could get them in the bath they could wash themselves instead of us doing it for them."

During our last inspection we had identified CCTV was in use and there were cameras in communal areas such as the lounge and dining room with no clear protocols as to why. This compromised people's privacy and dignity. Although during this visit the provider had set out their reasons for using them, it was not clear that the location and number of cameras and the continuous recording of people was in people's best interests.

This was a breach of Regulation 10 Dignity and Respect of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they had not had opportunities to participate in planning and reviewing their care. One person told us, "No I've never been asked." The registered manager explained to us they planned to involve people and their families in future reviews.

People told us most of the staff were caring and showed them kindness. Comments included, "Most of them are ok, some are better than others," and "They are nice people," and, "They are kind to me." We saw staff addressed people by their preferred names and explained what was happening when providing care interventions. Staff spoke with one another in a respectful way and were helpful towards each other in completing their care duties and supporting people.

Staff told us they cared about the people who lived at the service. One told us, "People are lovely, they are the most important people here." Another told us, "I really like the residents. I am fond of them all." However, when we asked staff if they would be happy for their relatives to live at the home. They all said 'no'. One said, "No, there is no stimulation, people look at the same four walls they never go out even to get a breath of fresh air. I wouldn't want that for my relative."

Overall, individual staff practice we observed demonstrated they cared about people. For example, a staff member saw that one person was crying and promptly offered them reassurance. The person explained they felt worried because their visitor hasn't arrived as expected. The staff member then fetched a telephone, so the person could contact their visitor to make sure they were okay.

We saw some staff bent down when they spoke with people, so they were on the same level, to be respectful. We saw one staff member spoke closely into the ear of a person, so they could hear what they were telling them clearly. However, we saw a staff member opened a window in the lounge without asking people. They told us, "It's a bit warm in here." We asked the staff member if people were warm and they replied they would close it "In a bit". The staff member had not considered if this would impact on people sitting in the lounge or if this was what people wanted.

Staff told us they had received training in equality and diversity, so they could fully support people's needs. One staff member told us, "Everyone is different, we respect people's differences."

We asked staff what caring meant to them. One said, "Having time to get to know people but we don't get that here." Another said, "Good care is personalised, we try but people don't get it here. The atmosphere is tense, and people pick up on that so if you are asking me if people get good care…. I would have to say, sadly, no."

People told us there were no restrictions on visiting times and their family and friends could visit whenever they wanted to help them maintain relationships with people that were important to them.

Inadequate

Is the service responsive?

Our findings

During our previous two inspections, we found improvements were needed in responding to people's individual needs. During this inspection, standards had further deteriorated and improvement was still required. Responsive has therefore been rated 'Inadequate'.

Action was not always taken to respond to people's healthcare needs in a timely way to prevent people from experiencing discomfort. For example, staff told us about three people who had "itchy" skin. A 'body map' for one person showed they had scratched their skin so much they had made it bleed. Although creams had been prescribed by the GP for the person, staff told us they had not been effective, and the person had continued to scratch their skin every day. The person told us, "They (care workers) do put my cream on but it doesn't work. I'm so itchy its driving me round the bend. I've been like it for months and I'm sore, it's not getting better." Medicine records were not available to confirm the cream was being applied. We therefore, could not be sure the person had received their cream consistently as prescribed to relieve their itching. We made the registered manager aware of this concern so that action could be taken to address this.

Prior to our inspection visits we had received information that a person at the home had an unexplained 'black' eye. During our visit, we identified this was correct. We saw the person had a bruised eye area and a body chart contained no explanation as to how the bruise had happened. There was a suggestion from a staff member that the person had done this themselves, but this had not been sufficiently investigated. We asked the registered manager if the person had seen the GP to check if there was any damage to their eye that required medical attention. The registered manager confirmed no appointment had been made with the GP. Records showed the person had acquired the 'black' eye for several days prior to our first visit. Action had not been taken to ensure the person accessed a GP in a timely manner to check if they required further medical attention. The registered manager arranged for the person to see the GP during our inspection after we had raised this as a concern.

Not all care plans contained detailed information to support staff in providing care that met peoples wishes and preferences. For example, one care plan stated, "Assist with personal care", this did not state in what way or what the person's preferences were such as a bath, shower or wash. Records did not make it clear what the person could to do for themselves and what staff should assist them with. Staff told us they didn't always have time to read care plans because they were so busy. One staff member told us, "Any changes we pass on verbally." This meant people may not always experience consistent care in a way they preferred.

During our last inspection we found issues related to people's nutrition, skin care and psychological needs that needed improvement. These areas continued to need improvement at this inspection. For example, we were told one person had wounds to both legs and was under the care of a district nurse. However, there was no care plan to inform staff that the person had wounds on their legs and to direct them what to do if dressings should fall off or become soiled. There were no instructions for them to observe the wound areas and what to look for that could suggest a concern. When the person had developed a skin tear, staff had incorrectly applied a dressing, as we saw from records, the dressing had stuck to the wound. There was no care plan to give staff direction on what they should do in response to these types of concerns, to ensure

the persons needs were met safely and effectively and did not cause further damage to the person's skin.

People continued to have limited opportunities to engage in meaningful activities in accordance with their preferences. One person said, "There is not much going on here. I would like a bit of company. Someone to talk to as I don't really like group activities." We asked the person if anyone had asked them how they liked to spend their time. They replied, "Not that I can remember."

We asked the registered manager what activities had been considered for people living with dementia. They told us, "We used to have reminiscence bingo and floor football but not anymore. Not sure why not." The registered manager told us the activities co-ordinator for the home was one of the apprentices that worked there. However, they confirmed this staff member had not received any training to help them support people with activities that were suited to their needs and abilities.
Following our last inspection action had been taken for some staff to complete dementia care training but the training records showed most staff were still to complete this. We had identified a training need at our last inspection to support staff to understand how to be more responsive to the needs of people living with dementia.

We saw a musical movement activity took place during the morning of one of our visits between 10 and 11am which several people participated in. Following this there were no further activities made available to people for the rest of the day.

There continued to be limited access to the local community to promote the service and enhance people's lives. One staff member told us, "The local school children came a few years ago to sing at Christmas. People liked it, but it hasn't happened again." Another staff member said, "It's a bit of a shame. People don't get chance to go out. There is a bus that goes past the home into town some people might like to go into town for coffee. We don't have events likes Christmas or Summer fetes as there is no one to organise them."

The provider had a policy on equality and diversity which staff were required to read when they started work at the home. There were both male and female staff available to support people's preferences, but we identified from speaking with one person that their preferences were not met. Arrangements were not in place to make sure people's gender preferences were identified and respected.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Person Centred Care.

Staff told us church services took place 'every now and again' at the home' which some people chose to attend.

Staff told us they attended a 'handover' meeting at the start of their shift where important information about each person that lived in the home was shared from their shift such as, how people were feeling. One staff member told us, "We have a communication book, so we can pass on information." We saw this was in place and that staff used this to keep up-to-date with people's appointments and changing needs.

Whilst care plans were not always sufficiently detailed they were reviewed on a regular basis to assess any changing needs and support required. Staff knew people well, they told us people were supported to receive some personalised care. For example, they knew one person did not like loud noises, so they encouraged the person back to their bedroom if loud music activities were taking place. Another person liked listening to the radio and they helped them to tune into their favourite station.

Care staff had an awareness of people's cultural needs and knew that one person did not eat beef. This was reflected in the persons care plan and the cooks were aware of this. Some information had been collected about people's life histories to help staff support people's needs and to assist staff in holding meaningful conversations with people.

We saw that people's communication styles had been assessed. For example, one person had slurred speech and they had a care plan that instructed staff to be 'patient and listen carefully' when they spoke with the person. We saw this happened during our visit.

Another person was visually impaired, and we saw they used a red cup and a red plate when they had something to eat or drink. This colour helped the person to see their eating utensils more easily which promoted their independence.

In regard to the planning of end of life care, we saw one person had a care plan that included information on their end of life wishes. It detailed that the person did not want to go to hospital if they became unwell. Their wish was to remain at the home. The person's chosen funeral director contact details were recorded. However, plans were not in place for all people at the home to ensure their care at this time was managed in accordance with their preferences.

There was a complaints procedure in place to support people to make any complaints. People told us they had not made any complaints and if they had any concerns, they raised them with staff. One person told us they had raised a concern about the heating in their room which was not working. They had made staff aware of this and we identified this was being acted upon at the time of our visit.

Inadequate

Is the service well-led?

Our findings

During our previous inspection, we identified improvements were needed in the management and leadership of the service. At this inspection we found this continued to be the case. Standards at the home had further deteriorated. We found improvements were needed across all of the key questions we assessed. Well-led therefore has been rated 'Inadequate'.

Our discussions with the registered manager confirmed they were aware of their responsibility to share information with local authorities and other regulators in relation to concerns linked to safeguarding people from the risk of harm. However, they had failed to report and share information when people had unexplained injuries and bruises. We identified six people had unexplained injuries and bruising to their skin and these had not been reported to us as required.

The lack of reporting notifiable incidents was a breach of the Care Quality Commission (Registration) Regulations 2009 (Part 4) Regulation 18 Notification of Other Incidents

The provider and registered manager had failed to ensure an effective system was in place to identify safeguarding concerns and to ensure any concerns were investigated and reported to keep people safe. At our previous two inspections the administrator had been tasked with analysing accidents and incidents. However, we had found this analysis had not been effective in informing the provider of any concerns. At this inspection, the analysis remained insufficient which placed people at significant risk of harm. This shortfall had not been identified by the registered manager and provider which meant no action had been taken to respond to some of the injuries people had sustained or to minimise the risk of them happening again.

Systems and processes to monitor the quality and safety of the service continued to be ineffective in ensuring the service was well managed. Audit checks completed by the management team and staff did not ensure risks were identified and acted upon. For example, we identified risks related to people's nutrition and identified people with unexplained injuries that had not been followed up and acted upon. Charts used to monitor people's food intake were not monitored and acted upon to ensure health professional advice was followed.

The provider had failed to have effective processes to check the environment and equipment people used was safe. Walking frames in use were in need of repair. We saw the carpet on a stair near to the front door was not securely fixed. This was a trip hazard. Checks of the environment had not identified some of the radiator covers were not secure which if moved and touched presented a burn risk to people. We saw a commode chair in use was unsafe as the arm of the chair was not attached to the frame and presented a risk of injury. We made the registered manager aware of these safety concerns and asked them to make arrangements to address them with immediate effect.

The provider had not identified through any audit checks that the environment placed restrictions on people's care and did not uphold their dignity. For example, people were not able to easily access toilets

and the shower room in accordance with their needs and wishes. At the time of our inspection visit there were no plans to address this despite this issue being raised at our previous inspection.

The provider did not have an effective system to ensure management checks and audit processes were effective in identifying ongoing risks to ensure they were addressed. For example, the risks of people's bedroom doors being wedged open. This concern had been raised at our previous inspections and by an external organisation who had completed a fire risk assessment for the provider. The registered manager had told us during our previous inspection that door retainer devices would be fitted to the doors of those people who wished to keep their door open. This had not happened.

On 17 October 2018 the registered manager undertook an infection prevention audit. This had failed to identify that cleaning schedules were not in place for the service and we found a number of infection control issues during our inspection. This included cracked tiles in a communal shower room on the ground floor which meant they could not be cleaned properly.

Staff training records had not been checked to identify gaps in staff training and ensure they were addressed in a timely manner. We identified several concerns in relation to staff practice suggesting training completed had not been effective or sufficient. This included concerns in relation to their understanding of fire safety, meeting people's nutritional needs, moving and handling people and infection control. The provider did not have a sufficient monitoring system to ensure staff worked safely, fully understood their role and what was expected of them.

Staff felt the home was not well led. Most staff told us they did not always feel supported and valued by their managers. Comments included, "They don't listen to us. They say they will sort things out, but they don't. The whole place is disorganised, nothing gets followed up and paperwork goes missing" and, "The place is really poorly managed. We just muddle through and that's not good for us or the residents."

Staff told us they had team meetings but the notes of these meetings had not been recorded to show topics of discussion and any potential areas for improvement raised. The 'staff meeting minutes folder' contained only one set of minutes which were dated January 2018 which was prior to our previous inspection. This meant the provider could not evidence staff were regularly involved in issues related to the effective running of the home.

At our previous two inspections, people and relatives had not been invited to share their views of the service. There was no formal quality monitoring process, such as meetings or surveys, so they had some influence over decisions related to the care and service they received. During this inspection, staff confirmed improvements had not been made. One staff member told us, "No, we should have them (meetings with people) monthly, but they don't happen." The registered manager confirmed meetings with people did not happen. They told us they planned to hold a meeting shortly after our visit.

People did not have opportunities to share their views through other means such as questionnaires about the service. Three staff members told us people were not asked their views on the service they received. One staff member commented, "There are no questionnaires or anything. There is a comments box in the front door, but people don't use it."

This was a breach of Regulation 17 Good Governance (HSCA 2008 (Regulated Activities) Regulations 2014.

Following our last inspection, the registered manager had taken action to review care plans so they contained more information about people. They had also implemented a 'daily records folder' that staff

used each day to record information about peoples care and health, so they were kept up to date on people's changing needs.

Following our last inspection, the provider had taken action to ensure the open hatch to the roof space was made secure to reduce the risk of people accessing this area.

The registered manager had been in post at the home for over 18 years, they were supported by a deputy manager, administrator (not available at time of inspection) and senior care staff. The registered manager had recently been absent from the home for a six week period and had returned shortly before our inspection visit. During the registered manager's absence the administrator and deputy manager had managed the home. The registered manager had told us about their planned absence, in line with their registration requirements and also understood their responsibilities to display their CQC rating so that people could see this.

Some people were positive in their comments of the registered manager. They told us, "She is always about, quite friendly," and, "She seems nice."

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 The care and treatment people received did not always meet their needs and reflect their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's privacy and dignity was not maintained to respect their wishes and independence.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected from risks associated with their health, safety and welfare because risks were not always identified and fully assessed to ensure care and treatment people received was provided in a safe way. This included risks associated with the environment and equipment people used.

The enforcement action we took:

Notice of Proposal to cancel the manager's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured suitable systems were in place to identify, assess and manage risks to people's health and safety so that people received safe care and treatment. This included risks associated with the environment and equipment. The management of fire safety was not sufficient to ensure safe procedures were followed in the event of a fire.

The enforcement action we took:

Urgent Notice of Decision with 5 conditions placed on the provider's registration