Bethesda Healthcare Ltd

Kinross

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service:
Kinross is a residential care home providing personal care to 20 people aged 65 and over at the time of the inspection. The service can support up to 29 people. Accommodation is based on two floors connected by stairs and a passenger lift. There is a range of communal areas on the ground floor including a dining room and two lounges.

People's experience of using this service and what we found:
There was a lack of effective oversight of the service by the provider, caused by inconsistent management and inadequate quality assurance processes. Some improvements identified in the action plan developed after the last inspection had not been fully addressed or sustained.

The safety of people using the service was not assured. Individual risks to people were not always managed effectively, including those relating to falls, pressure injuries and scalding. Family members expressed concerns about staffing levels and we staff rotas confirmed there were rarely enough staff to support people safely in the evenings.

The systems to investigate and report allegations of abuse were not robust and put people at risk of harm. The provider had failed to comply with the requirements of their registration as they had not notified CQC of multiple incidents of abuse.

People were not always supported to have maximum choice and control of their lives as staff had not consistently followed legislation designed to protect people's rights and their best interests.

People told us staff were competent. However, we found the induction procedure was not robust and staff did not receive supervision as frequently as required by the provider's policy.

Assessments of people's needs were completed before people moved to the home, but accurate records of referrals to healthcare services were not always kept, to show they had been made promptly when needed.

Staff had built positive relationships with people and supported them in a patient way. However, they sometimes showed a lack of consideration for people and people's privacy was not always protected.

Staff understood and met people's needs, although care plans were not always up to date and did not support the delivery of personalised care; however, most care plans were updated during the inspection once we had identified the concerns to managers. People had not been given the opportunity to discuss their end of life wishes and preferences, although staff expressed commitment to supporting people with compassion at the end of their lives.

Medicines were usually managed safely. The home was clean and infection control procedures had

improved significantly. People received enough to eat and drink. Adaptations had been made to the environment to make it supportive of the people who lived there.

Independence was promoted and people were supported to express their views. A range of activities was provided. There was an accessible complaints procedure in place and people felt able to raise concerns.

Managers sought and acted on feedback from people.

We found evidence that the provider needs to make significant improvements. Please see the key questions section of this full report.

Rating at last inspection and update:
The last rating for this service was inadequate, the report for which was published on 16 February 2019. There were multiple breaches of regulation. We issued three warning notices requiring the provider to make improvements and placed the service in special measures. The provider sent us an action plan to show what they would do and by when to improve.

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

At this inspection, we identified six breaches of regulation in relation to consent, safe care and treatment, safeguarding people from abuse, staffing, good governance, and notification of serious incidents.

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

Why we inspected:
This planned inspection, based on the previous rating, was brought forward due to concerns we had received about incidents of abuse, medicines management, infection control, staffing levels, risk management and record keeping. A decision was made for us to complete a comprehensive inspection to include an examination of those risks. We also followed up on the action we told the provider to take at the last inspection.

Follow up:
We will continue to monitor information we receive about the service until we 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 remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Kinross

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 and an Expert by Experience in the care of people living with dementia. 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
Kinross 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 did not have a manager registered with the Care Quality Commission. This meant only the provider was legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
Before the inspection, we reviewed information we had received about the service, including previous inspection reports, the action plan the provider sent us following the last inspection, and notifications. Notifications are information about specific important events the service is legally required to send to us. We also received information from the local authority safeguarding team. We used all of this information to plan our inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is

information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with 15 people who used the service and five relatives about their experience of the care provided. We spoke with the provider's nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with the provider's general manager, the home manager, the previous home manager (who currently acts as a consultant for the provider), six care workers, a housekeeper, a maintenance worker and a chef. 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 multiple medication records. We looked at three staff files in relation to recruitment and staff supervision and a variety of records relating to the management of the service, including policies and procedures.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at staffing records, training data and quality assurance records. We sought feedback from three healthcare professionals who regularly visited the service. We also shared our safeguarding concerns with the local safeguarding team and checked the provider had notified them retrospectively of allegations of abuse that we identified during 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 Inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management
At our last inspection the provider had failed to assess the risks relating to the health, safety and welfare of people. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, not enough improvement had been made and the provider continued to be in breach of this aspect of Regulation 12.

• When people experienced falls, appropriate action was not always taken to prevent further falls. One person had experienced five falls over a three-month period, most of which had been in their bedroom. Staff were using 'crash mats' when the person was in bed to protect them if they fell out of bed; however, the need for these had not been recorded in the person's care plan and there was no evidence to show that staff had considered other measures to reduce the risk, such as reviewing the layout or lighting in the person's room Staff had also not completed a multi-factorial 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.
• The tool staff were using to assess the likelihood of a person falling was not effective. It did not consider the number of previous falls experienced by a person, which is an accepted predictor of future falls. Hence, the level of risk posed to people who had experienced multiple falls had not changed over time, despite the obvious increase in the likelihood of them falling again. Because the level of risk remained the same, their falls care plans had not been reviewed to consider additional measures that might protect the person.
• Managers monitored the incidence of falls. However, their analysis was more focused on whether staff had taken the correct action at the time of the fall, rather than considering strategies to prevent further falls. Their falls prevention strategy was limited to requesting a referral to the falls clinic, taking urine samples for analysis and conducting hourly checks of the person.
• Records showed that referrals to the falls clinic had not been made in a timely way. The current home manager had recognised this and had recently made retrospective referrals for people who had fallen over the previous six months. This meant there had been an unnecessary delay in obtaining specialist advice that might have prevented people falling.
• One of the people using an alert mat to protect them from the risk of falls had been put at increased risk because the covering of the mat was torn. This created a trip hazard. We brought this to the attention of the home manager, who immediately took it out of service.
• Staff did not take a consistent approach in supporting a person at risk of pressure injuries. The person had been identified as at high risk of pressure injuries had been given a pressure-relieving mattress, but the need for this was not recorded in their care plan. Their care plan stated staff should support the person to

reposition "once in bed", but did not specify how often. The were no records to show the person was being supported to reposition and staff had conflicting views about whether this was necessary. The care plan also instructed staff to check the person's pressure areas twice daily, but records had not been kept to show whether this had been done over a three-day period. These issues posed a risk that the person's skin integrity needs would not be met consistently.
• Environmental risks were not always managed safely. Weekly checks were conducted to help ensure the temperature of the hot water at outlets in people's rooms was not too hot. However, records showed that no action was taken when the readings were repeatedly above the recommended safe limit of 42 degrees Celsius. This put people, including those with cognitive impairment, at risk of scalding.
• Personal emergency evacuation plans had been completed for each person. These were designed to inform staff and emergency services of people's needs in the event of an evacuation. Two copies of these were in use, containing conflicting and inaccurate information. This could compromise the safety of people living at the home who were not on the list. Attending emergency services could put themselves at risk searching for people who were on the list but no longer lived at the home.

Systems were not robust enough to demonstrate safety was managed effectively. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Checks of the fire safety systems were conducted weekly and showed the systems were working correctly.

Learning lessons when things go wrong
• There was a process in place to monitor incidents, accidents and near misses. However, these were not operating effectively, for the reasons described above. In addition, we found action was not always taken to address the cause of incidents.
• For example, when a staff member caught a person's leg on a hoist, there was no evidence of any investigation to establish how it had occurred. The staff member was not offered any additional training and their practice was not checked to make sure they knew how to operate the hoist safely. Neither was the person's moving and handling care plan reviewed, to consider whether alternative support or equipment might be more appropriate. The home manager told us they would review the service's response to such incidents.
• Staff told us they felt able to openly report mistakes, so remedial action could be taken. For example, a staff member told us, "I would feel confident reporting any [medicine] errors as we care about the residents."

Staffing and recruitment
At our last inspection the provider had failed to ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed to support people in a safe way. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, not enough improvement had been made and the provider continued to be in breach of Regulation 18.

• People told us their call bells and requests for help were answered in reasonable time and a family member said, "There does seem to be enough [staff] when I come in". However, other family members expressed concerns about the staffing levels. These included: "Sometimes I wonder if there are enough staff. Some days, although not always, there is no member of staff in the lounge, which I think is not right" and "There's only two staff on at night, I believe, so if they are distracted by [domestic tasks] is that enough staff for 25 people?"
• The provider used a dependency tool, based on people's needs, to calculate the number of staff required. A

review of the rotas showed the assessed number of day staff were usually provided. However, the assessed number of night staff needed between 8:00pm and 8:00am was not usually met.
• The dependency tool specified the need for 2.6 staff at night. The home manager told us they met this need by deploying two staff on full nights, plus a third staff member on a 'twilight shift' until 10:00pm to help support people to bed. However, records showed that during the previous 42 days, the 'twilight shift' was only covered on seven evenings.
• This was contrary to the assurances given after the last inspection when the provider's nominated individual told us they would re-instate the 'twilight shift' that had previously been stopped without their knowledge.
• This meant that between 8:00pm and 10:00 pm, when staff were busy supporting people to bed, only two staff members were usually available. Staff told us up to four people needed the support of two staff members in the evenings. If only two staff members were available, and they were both supporting one of these people to bed, then no staff would be available to support people in the communal areas of the home.
• Although we did not find any evidence of anyone coming to harm, it meant people were not supported by the number of staff calculated as needed and put them at risk of harm. The home manager told us additional staff were being recruited to provide additional cover in the evenings going forward.

Staffing arrangements were not robust enough to demonstrate that sufficient staff were deployed at all times to meet people's assessed needs. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• There were clear recruitment procedures in place to help ensure only suitable staff were employed. These had been followed in all but one of the cases that we looked at. In this case, a full employment history had not been obtained for one staff member. The provider had not confirmed what the staff member had been doing during these periods, so could not assess whether it impacted on their suitability for employment.
• We raised this issue with the home manager, who assured us they would address the issue and ensure full employment histories were recorded for all staff in the future.

Systems and processes to safeguard people from the risk of abuse
• The systems designed to protect people from the risk of abuse were not always effective. One person had been involved in 15 incidents of sexual abuse in the month before the inspection, all of which were recorded in their care records. Staff had completed incident reports for three of these incidents, which the home manager had investigated and referred to the local safeguarding team. However, they had not completed incident reports for the remaining 12 incidents. As a result, the home manager was not aware of them; they had not conducted any investigations or referred them to the local safeguarding team, so measures could be considered to protect people from further abuse and inform the families of those affected.

The systems to investigate and report allegations of abuse were not effective and put people at risk of harm. This was a breach of Regulation 13 (Safeguarding people from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Nevertheless, we found staff were aware of the above incidents and the risks posed to people by the person. These were recorded in the person's support plan, that had been developed in conjunction with a mental health specialist, and staff had taken some action to protect people from the risk of further abuse.
• Staff had received training in safeguarding adults. They were able to describe the different types of abuse and the action they would take if they thought people were at risk.
• People told us they felt safe at Kinross. For example, one person said, "I feel very safe here, the carers are lovely" and a family member said, "[My relative] wasn't safe at home, so putting her in here reassures the family she's in good hands".

• Following the inspection, at our request, the home manager made appropriate referrals to the local safeguarding team in accordance with the provider's safeguarding policy.

Using medicines safely
At our last inspection the provider had failed to ensure the safe management of medicines. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found action had been taken. There was no longer a breach of this aspect of Regulation 12, although further improvement was still required.

• Clear protocols were not always 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". Although staff described the circumstances when they would administer the sedatives, the guidance available was not sufficiently clear to ensure these people would receive the medicines in a consistent way.
• Medicines that needed to be kept at low temperatures were kept in a fridge. Although there was a process to check that the temperature of the fridge remained within safe limits, this was not done consistently. In the week before our inspection, the temperature had not been checked at all. When we checked the recorded high and low readings, they indicated the temperature had been above the recommended limit at a time that could not be determined. This meant the medicines being stored might not have been fully effective when used.
• We raised the above issues with a senior member of staff who addressed them immediately.
• Medication administration records (MARs) confirmed that people had received their regular medicines as prescribed.
• Arrangements were in place to help ensure time-specific medicines were given at the right time. Risk assessments had been completed for people whose medicines put them at increased risk of bleeding and for topical creams that posed a fire risk.
• Medicines were administered by trained staff who had been assessed as competent to administer them.

Preventing and controlling infection
At our last inspection the provider had failed to prevent and control the risk of infection. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found action had been taken and there was no longer a breach of this aspect of Regulation 12.

• Improvements had been made to the laundry facilities and there was a clear system in place to prevent cross contamination. The sluicing facilities had also been improved and now included a dedicated hand washing sink for staff.
• Staff had been trained in infection control techniques and followed safe operating procedures to reduce the risk of infection; for example, they used personal protective equipment, including disposable gloves and aprons, when delivering personal care to people.
• All areas of the home were clean and staff completed regular cleaning in accordance with set schedules.

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 has remained the same. This meant the effectiveness of people's care, treatment and support still did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
At our last inspection the provider had failed to ensure that people only received care and support with consent. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, not enough improvement had been made and the provider continued to be in breach of Regulation 11.

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.

• Where people did not have capacity to consent to the care and support provided, MCA assessments and best interests decisions had not always been completed. For example, they had not been completed for a person who clearly lacked capacity to make decisions about the use of a sensor mat to monitor their movements. This meant staff could not confirm whether it was in the person's best interests to be monitored in this way, or that this was the least restrictive option.
• Two people had capacity to consent to their care when they arrived at the home, but over the passage of time their cognitive ability had declined. Staff told us these people were no longer able to make informed decisions about aspects of their care, including the administration of medicines and the use of equipment to monitor their movements. They had made decisions to provide the support in the best interests of the person. However, the decisions had not been assessed or recorded in accordance with the MCA and its code of practice.
• For another person, we saw staff had recorded a best interest decision about the use of bed rails but had not completed an MCA assessment first, to consider whether the person was able to make the decision for themselves or with support.
• For a further person, the previous home manager told us they had completed MCA assessments and best interests decisions but these could not be found. The absence of an accurate record of the person's capacity to make decisions meant there was a risk their rights would not be protected.

The processes to assess people's capacity and record best interest decisions were not robust and risked

compromising people's rights. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and found that they were.

• Applications for DoLS had been submitted to the appropriate authorities as required. The home manager told us they were reviewing the needs of everyone living at the home to assess whether any further applications were required.
• The home manager and staff understood their role and responsibilities in relation to DoLS.
• There was a system in place to help ensure applications to renew DoLS authorisations were made before they expired.

Staff support: induction, training, skills and experience
• People and family members told us staff were competent and supported them well. Comments included: "The staff know what they're doing", "They look after us very well here" and "[My relative] gets good care here and she's settled in well".
• However, we identified some concerns with the quality of staff training. For example, a handout used as part of staff's MCA training was misleading as it did not reflect the principles of the act.
• The induction process was not robust and provided a minimal level of training to staff. For example, records showed that new staff had completed up to 14 topics on the first day of their employment. We could not be assured that staff could effectively absorb and retain such a high volume of topics, particularly if they had not worked in care before.
• One of the topics included 'moving and handling'. Guidance issued by The Health and Safety Executive (HSE) recommends that this should have a practical element, using the relevant equipment to ensure staff understood how to use it correctly. Some staff told us they learnt how to use the hoist and the stand-aid by working alongside other staff rather than during a dedicated course by an accredited trainer. Therefore, we could not be assured they had learnt the correct techniques, and this put people at risk of harm.
• Staff who were new to care were not consistently supported to complete training that followed the Care Certificate. The Care Certificate is an identified set of standards that health and social care staff adhere to in their daily working life. Although one staff member had completed this, the information on other staff members' enrolment and progress towards it were not clear as none had a plan or a timetable for completion. Therefore, we could not be assured they would complete the certificate within the recommended timescales.
• Training was not always provided to meet the identified needs of staff. Following an incident where record keeping was identified as a significant concern, the need for additional training was recognised. However, a month later this had still not been arranged.
• We raised the above concerns with the provider's training manager who told us they would work with the home manager to review the training pathway for new staff.
• Of the night staff, we noted that only one was trained to administer medicines, which meant that on some nights there was not a medicine trained staff member on duty. Staff told us that if someone needed 'as required' medicines at night, they would have to contact the on-call supervisor. The need to wake a colleague to do this might discourage staff from making the call.
• The home manager acknowledged this and told us they planned to train more night staff to administer medicines. They also assured us they would clarify the arrangements for checking the practical ability of staff to administer medicines safely, as there was not a consistent process in place for this.
• Staff were supported through one-to-one sessions of supervision. These provided an opportunity for one of

the managers to meet with staff, discuss their training needs, identify any concerns, and offer support. Staff spoke positively about the support they received from managers on a day to day basis, describing them as "supportive". Junior care staff also praised the support they received from senior care staff; for example, one staff member told us, "[Senior's name] is brilliant. You can ask anything and don't feel you are being a pain."
• However, records showed that supervisions were not held as frequently as the provider's policy required. The policy specified every six to eight weeks, but we found no supervisions had been completed in the previous three months and some staff had not received a supervision for over six months. The home manager told us they would take steps to ensure staff received more regular supervisions in future.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
• People and their relatives felt staff provided effective care.
• Assessments of people's needs were completed before people moved to the home. These identified people's needs and the choices they had made about the care and support they wished to receive.
• A range of nationally recognised tools were used to monitor people's health and wellbeing in line with best practice guidance. For example, staff used a nationally recognised tool to assess people's risk of pressure injuries. However, we found some of these had not been updated for three months, contrary to best practice guidance that recommends monthly updates. This meant there was a risk that people's skin care needs were not accurate or up to date. We raised this with the home manager and they immediately started the process to update the relevant assessments.
• Staff made appropriate use of technology to support people. For example, an electronic call bell system allowed people to call for assistance when needed. In addition, pressure-activated alarms, linked to the call bell system, were used to alert staff when people moved to unsafe positions. WiFi had also been installed to enable people to keep in touch with family members via video conferencing applications.
• We observed staff followed safe practices when supporting people to move.
• A system was in place to check the pulse rate of a person before administering a heart medicine, in line with the manufacturer's instructions and best practice guidance.

Supporting people to live healthier lives, access healthcare services and support; Working with other agencies to provide consistent, effective, timely care
• People told us they were supported to access healthcare services and GPs when needed. However, record keeping on people's files did not confirm that this was always done in a timely way.
• For example, one person's care records spoke of the need for a referral to an occupational therapist in November 2018, but there was no record to confirm this had been made. A visiting social care professional had identified the need for another person to be referred to a specialist mental health team and to their GP for a review of their medicines. Again, there was no record to confirm whether this had been done and staff were unclear about who should have made the referral. A GP had asked staff to check a person's blood pressure, but there was no record to show if this had been done either.
• The home manager was unable to confirm whether or the not the above referrals had been made, so made them following the inspection. The failure to maintain clear records about referrals meant people might not have received appropriate healthcare.

The failure to maintain accurate, complete and contemporaneous records of the care and support provided was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Other people had been referred to healthcare services promptly. For example, when person started behaving in a way that put themselves or others at risk, an immediate referral was made to the mental health team.
• Staff told us that when people were transferred to hospital or another care setting, essential information

was sent with them, including information about their medicines and individual care needs. This helped ensure continuity of care for people.

Supporting people to eat and drink enough to maintain a balanced diet
• People were complimentary about the food. Comments included: "I enjoy my food" and "Lunch was delicious".
• People were provided with a choice of two main meal options, however they could request alternatives if required. For example, one person told us, "I'm having a bacon sandwich for lunch, they do it especially for me".
• Where people required specific adaptions to the way their food or drink were prepared and served, this was identified in their care plans and followed by staff. However, for one person there was a discrepancy between information in their care plan and advice from a speech and language therapist. This meant the person might receive food of an inappropriate texture that put them at risk of choking.
• We raised this with the home manager, who assured us they would update the person's care plan. The risks to people were reduced as staff had a good understanding of people's dietary requirements and meals were provided according to people's needs and preferences.
• People who needed support to eat were assisted with patience, by staff who engaged with them well.
• 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."

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, a passenger lift gave access to the first floor of the home and handrails were painted in contrasting colours to make them more visible. In addition, lights came on automatically in the toilets, which ensured they were always well-lit.
• Since the last inspection, additional 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. 'Memory boxes' had been installed outside people's bedrooms. These were glass-fronted cases into which people had placed personal memorabilia and items they would recognise to help them find and recognise their own room.
• We viewed plans for further enhancements to the environment, including new carpets, chairs and decoration that would support the needs of people living with cognitive impairment.
• Some people had personal items such as pictures and mementoes in their rooms and some had small items of personal furniture.
• The gardens consisted of a large lawn area which people said they could use if they wished.

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 Requires improvement. At this inspection this key question has remained the same. This meant people might not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity
• Staff did not always show consideration for people. On checking a sample of beds that had been made ready for people to use, we found the duvet on one was wet and stained with urine; another had been made using a valance sheet instead of a flat sheet, so was creased and put the person at risk of pressure injuries; and a third bed had been made without a bottom sheet, which meant the person would have been lying directly on the plastic-covered mattress.
• We raised these concerns with senior staff, who acted immediately to re-make the beds properly.
• When viewing a sample of daily records where staff had recorded the care and support given to people, we found the use of language was not always appropriate. For example, on two occasions, a person's continence pad had been referred to as "a nappy" which infantilised the person. On other occasions staff had talked about people being "uncooperative and argumentative" which indicated staff were not always led by the person's wishes.
• We brought these examples to the attention of the home manager, who acknowledged the use of such phrases was not appropriate. They told us they were planning to deliver record-keeping training to staff, which would address this.
• People and relatives told us they enjoyed positive relationships with staff. One person told us, "I like the carers; they do look after us well". A family member said, "I've got no problems with staff, they treat [my relative] lovely."
• Without exception, all the interactions we observed between people and staff were positive, polite and respectful.
• Staff showed concern for people's comfort and repeatedly checked whether people needed cushions or extra clothing. When a person fell asleep with their head on the arm of the chair, several staff members tried to make them more comfortable. Another person who became uncomfortable was offered a pillow for their head. The staff member told us, "I do want [the person] to be comfortable, she can't help herself."
• People's protected characteristics under the Equalities Act 2010 were identified as part of their needs assessments before they moved to the home. Most people's care plans included information about their background, lifestyle choices, important relationships and circles of support. Staff recognised people's diverse needs and there were policies in place that highlighted the importance of treating people as individuals.
• We found staff knew people and their life histories well and used this information to engage positively with people. A healthcare professional confirmed this and added, "The staff are so knowledgeable. They know people inside out. They are very aware of each resident, their background and what they've done in their lives."

Respecting and promoting people's privacy, dignity and independence
• People's privacy was compromised as there were no locks provided on the toilet doors; however, we drew this to the attention of the home manager and they arranged for locks to be fitted immediately.
• People's privacy was protected while personal care was being delivered. Staff described the practical steps they took help ensure people's dignity was upheld, including through the use of privacy screens when supporting people in shared rooms.
• People could choose the gender of the staff member who supported them with personal care and this was respected.
• Confidential information about people was kept securely in locked cabinets or locked rooms.
• Staff promoted independence by encouraging people to do as much of their personal care as they could manage. One staff member told us, "With [one person] I get the water ready and offer the flannel and they can manage then. If [the person] needs the toilet, I'll point towards the blue door, they recognise this now and will go on their own."
• People's care plans provided information for staff about what people could do for themselves and where additional support may be required. For example, one care plan stated, "I need full support with personal care but can wash my face and hands."

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.
• Family members were 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, it makes us reassured."
• People were also given the opportunity to express their views on an on-going basis with staff and during 'residents meetings'.

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 Requires improvement. At this inspection this key question has remained the same. This meant people's needs were still not always met.

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

• Each person 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, the catheter care plan for one person could not be found. A catheter is a device that drains fluid from a person's bladder into an external bag. They are prone to blockages and infection, so it is important to check they are flowing freely. Staff told us they checked for blockages by recording the person's fluid input and output on a chart; however, we saw that when no output had been recorded on the chart for periods of up to two days, indicating the catheter might be blocked, no action was taken.

• For another person, there was a clear catheter care plan in place, but their fluid output chart also showed no output for up to two days with no action being taken.

• 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. Two versions of the logs were being used, one of which did not ask about the triggers that had led to the incidents. This meant staff were unable to develop a robust plan that supported the person by reducing potential causes of the behaviour. The provider's consultant told us these were old forms that should no longer be used.

• Staff told us they supported people to have baths as often as they wished; however, bathing records did not reflect this. The records showed that, for up to a week at a time, no one living in the home was offered or given a bath. The provider's consultant told us staff should offer each person a bath daily and record it in the person's daily notes; however, on checking people's daily notes, they found this had not been done. Although people did not raise concerns, the lack of records meant we could not be assured that they were receiving appropriate support to bathe.

• 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."

• There was no evidence that people had come to harm as a result of the above concerns. However, the lack of information in people's care records put people at risk of receiving inappropriate or inconsistent care.

The failure to maintain accurate, complete and contemporaneous records of the care and support provided was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Other peoples' care records were more complete. For example, there was a comprehensive plan to support another person when they acted in a way that put others at risk. This had been developed in collaboration with a mental health specialist and had been used successfully to reduce the frequency of incidents.
• In addition, by the end of the inspection, most people's care plans had been updated to address the concerns we had identified. The home manager told us they would update the remainder as a priority.
• People and family members told us they were happy with the care and support provided and said staff treated them as individuals. A family member told us, "Overall, [my relative] seems happy enough here and she gets good care, we believe."
• Family members also told us staff responded promptly when people's needs changed. One family member said, "Staff are really on the ball. [My relative] gets [infections] and they spot the symptoms, do a [urine] dip test and get her on antibiotics." A healthcare professional echoed this and said, "When [a person] came out of hospital, they noticed his behaviour had changed and within a week had got me in to assess him."
• Staff understood people's needs well and knew how to support people according to their individual wishes. They spoke knowledgeably about the health status of people and things that affected their quality of life and the ways they provided support to try and improve this.
• 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. For example, when a person asked for support to go to bed and then changed their mind, we saw the staff member was not fazed and happily supported the person back to the lounge.
• Staff adapted their approach for each person to encourage them to make positive choices and experience good outcomes. For example, they sang and danced with one person to encourage them to go to their room to change their trousers; the person responded well to this and happily went off with the staff member.
• A staff member described how they supported people living with cognitive impairment to make decisions by "showing them things, making eye contact and explaining in a way they understand".

End of life care and support
• No one living at the home was receiving end of life support at the time of the inspection.
• However, there was no information recorded in anyone's care plan to demonstrate that their wishes and preferences in relation to end of life care had been explored.
• The provider's consultant told us they only developed end of life plans once the GP had started the person on an end of life pathway. However, this might be too late if the person becomes suddenly unwell or experiences sudden death. In this event, staff would not be aware of any wishes or preferences, cultural or spiritual needs that would have been important to the person.
• Most staff had experience of supporting people at the end of their lives and expressed a commitment to ensuring people experienced a comfortable, dignified and pain free death.
• The home manager acknowledged that end of life care planning was an area for improvement. They told us they intended to work with a local hospice and introduce the 'six steps' end of life training programme for staff.
• Written feedback to the provider from a family member whose relative had died at the home was highly complementary. Their comments included: "I couldn't of wished for a better place for [my relative] to have spent her last few days".

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 menu and the activities programme were available in picture-based formats, although we found these used very small pictures that most people would have struggled to see.
• The provider's nominated individual acknowledged that these could be further improved and undertook to do this. They also told us they were preparing 'mood boards', to support people to make choices about the colour scheme for their rooms, in advance of them being decorated.

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
• People had access to a range of activities. These included daily exercise sessions, story-telling, bingo, music, poetry and quizzes.
• These were provided by staff and by external activities providers and were well received by people.
• A family member told us, "[My relative] seems to enjoy the activities and joins in."
• The provider's nominated individual told us activities were based on what people enjoyed. However, they had recognised the need to tailor activities to better reflect people's interests and told us they would work on this to further enhance the activity provision.

Improving care quality in response to complaints or concerns
• There was an accessible complaints procedure in place. This was made available to people and advertised on the home's notice board. No complaints had been recorded since the last inspection.
• People told us they felt able to raise concerns and were listened to. A family member said, "If I do complain the staff do put things right, I'm pleased to say."

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 Inadequate. At this inspection this key question has remained the same. This meant there continued to be widespread and significant shortfalls in service leadership. Quality assurance systems 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

At our last inspection the provider had failed to operate effective systems to assess, monitor and improve the quality of the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, not enough improvement had been made and the provider continued to be in breach of Regulation 17.

• A registered manager was not in post at the time of the inspection. 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. The service was being run by a home manager who had been in post for eight weeks and told us they intended to apply to become registered with CQC.
• Since the service was registered in February 2018 there has never been a registered manager in post. Two previous managers had started the process to register but this had not been completed. In that time, the service had been managed by four different home managers, supported by three different deputy managers. This had resulted in a lack of continuity in the operations of systems to support the way the home was run.
• For example, the previous home manager had a system to refer people who had fallen three times to their GP and to update their care plans, but this system had not been followed by the current home manager. Similarly, the previous home manager had a system to update people's skin integrity risk assessments every month, but this system had not been continued. Also, the system to record when people were offered and received baths had not been carried forward. This lack of continuity put people at risk of harm or of receiving inappropriate care and support.
• Since the last inspection, the provider had not conducted a comprehensive review to assess whether it was meeting the fundamental standards of quality and safety. Some individual audits had been conducted, but these had not been adequate and had not identified the concerns found during the inspection. For example, they had not identified or addressed the failure to investigate and report incidents of abuse; they had not identified or addressed the ineffective approach to the management of falls; they had not identified or addressed the failure to ensure enough staff were deployed consistently. You can find more information about these issues in the Safe section of this report.

• Since the last inspection, there had not been an audit of staff training or supervision, so the concerns we identified with the quality and effectiveness of training and the low level of staff supervision had not been identified or addressed. You can find more information about these issues in the Effective section of this report.
• Senior staff were expected to check that people's beds had been made correctly, but this arrangement was not effective on the first day of the inspection when we found some beds had not been made correctly. There was not a process in place to review the content of people's daily notes, so the inappropriate use of language by staff had not been identified or addressed. You can find more information about these issues in the Caring section of this report.
• The process to ensure care plans were reviewed regularly was not being followed. The provider's consultant told us they had developed a tool for this and were planning to introduce it as part of a 'resident of the day' programme. However, they acknowledged that this had not been implemented yet.
• Individual reviews of some aspects of people's care plans had not been effective as they had not picked up any of the inaccuracies, inconsistencies or concerns we identified with the care plans and daily notes that we viewed. You can find more information about these issues in the Responsive section of this report.
• Systems to assess and monitor health and safety issues were also not effective. Although weekly checks of the hot water temperatures had identified many were too high, the concerns were not flagged up to managers, so no action had been taken to rectify them. When checks of equipment had identified the need for repairs, there was no clear process to make sure these were completed. For example, we were unable to confirm whether a broken castor on a hoist had been repaired, as records were not kept.
• An action plan had been developed following the last inspection. The provider's consultant, who had acted as the previous home manager, told us the plan had been completed. However, we found this was not the case.
• These included: a failure to ensure the 'twilight shift' was covered consistently; a failure to complete all required MCA assessments; a failure to ensure referrals to healthcare professionals were made in a timely way; a failure to ensure a full employment history was available for all staff; a failure to ensure staff supervisions were held regularly; and a failure to ensure people were supported to bathe as often as they wished.
• Monitoring by the provider was conducted through daily visit to the home by the provider's general manager or the provider's nominated individual. In addition, formal monthly meetings were held between the home manager and the provider's general manager to discuss emerging and ongoing issues. However, they had not validated the action plan produced after the last inspection to confirm that all identified issues had been fully addressed or sustained.

The failure to operate effective systems to assess, monitor and improve the service was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Providers are required to notify CQC of significant events that occur. We identified 16 incidents of abuse or allegations of abuse that occurred in April and May 2019 that had not been notified to CQC. This meant CQC was not able to monitor the service effectively to enable them to carry out their regulatory responsibilities. The home manager acknowledged this was an oversight on their part and assured us they would submit notifications promptly in future.

The failure to submit notifications when required was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

• Providers are also required to clearly display the rating of their CQC inspection on their website and on the premises. At the start of the inspection, we found the rating was not displayed on the provider's website and was not displayed on the premises, although a copy of rating was found behind other literature in the entrance hall. We raised this with the general manager and the home manager, who remedied these issues immediately.
• Staff told us they felt the service was improving, but acknowledged further improvement was needed. In particular, they raised concerns about staff retention.
• The home manager and the provider's consultant acknowledged that staff retention was a significant challenge. They said this had resulted in them and the training manager having to cover night shifts, which impacted on their day to day responsibilities. Of 13 staff recruited in January 2019, they said none remained. However, the provider had not conducted exit-interviews to help understand why staff retention was so poor.
• The home manager told us they would consider introducing exit interviews and moving to a values-based recruitment procedure to aid staff retention. They said they also planned to improve the induction and support arrangements for staff.

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

Continuous learning and improving care
• As mentioned earlier in this section, we identified issues that had not been addressed since the last inspection, together with continuing breaches of regulation. However, we also found areas that had been improved. These included improvements to the laundry and the sluice, to the environment, to the management of medicines and to aspects of staff training.
• The nominated individual told us they also shared feedback from inspections of other homes run by the provider to support improvement across all the provider's homes. This was done through a series of 'team briefings'.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• 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."
• Managers sought feedback from people during 'residents meetings' and in one-to-one discussions with people. People's feedback was used to improve the service. For example, people had asked for more fruit on the menu and more exercise sessions and both had been arranged. The results of people's feedback were displayed on "You said, we did" posters so people and their relatives would be aware.
• Staff told us they felt engaged in the way the service was run. Comments from staff included: "It's a happy, friendly place here", "It's a happy atmosphere, we can always ask for help" and "I'm very happy working here. Everyone is lovely and the bosses are good. I get on with them, they're very easy-going".
• The general manager described an investigation they had conducted into an allegation of racism by staff. This was thorough and demonstrated a commitment to ensuring people's protected characteristics under the Equality Act were respected and protected.

Working in partnership with others

• Staff had developed links with resources in the community to support people's needs and preferences. These included tissue viability specialists and the Older Persons Mental Health team. However, as mentioned in the Effective section of this report, referrals were not always made in a timely way.
• In addition, links had been established with a pre-school group, whose children and parents visited the home twice a month to interact with people. Staff told us this was very popular with people, who loved to meet the children.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had not failed to notify CQC without delay of incidents of abuse and allegations of abuse. Regulation 18(1) & (2)(e)

The enforcement action we took:

We issued the provider with a fixed penalty notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured that people only received care and support with the consent of the relevant person. Regulation 11(1), (2) & (3)

The enforcement action we took:

We varied the conditions of the provider's registration to require them to submit monthly audits of the service to enable CQC to monitor improvements.

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 that risks to people's safety were managed in a safe way. Regulation 12(1) & (2)(a)&(b)

The enforcement action we took:

We varied the conditions of the provider's registration to require them to submit monthly audits of the service to enable CQC to monitor improvements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not ensured that systems and processes were operated effectively to prevent and investigate incidents of abuse. Regulation

13(1), (2) & (3)

The enforcement action we took:

We varied the conditions of the provider's registration to require them to submit monthly audits of the service to enable CQC to monitor improvements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that systems and processes were established and operated effectively to assess, monitor and improve the service. They had also not maintained accurate, complete and contemporaneous records of the care and treatment provided to people. Regulation 17(1) & (2)(a)&(c)

The enforcement action we took:

We varied the conditions of the provider's registration to require them to submit monthly audits of the service to enable CQC to monitor improvements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that sufficient numbers of suitably qualified staff were consistently deployed to meet people's needs. Regulation 18(1)

The enforcement action we took:

We varied the conditions of the provider's registration to require them to submit monthly audits of the service to enable CQC to monitor improvements.