# Belmont Healthcare (Madeira) Limited

# Madeira Lodge

## 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
Madeira Lodge is a residential care home providing accommodation and personal care to up to 48 people. The service provides support to older people with varying care needs including, dementia, diabetes and mental health needs. At the time of our inspection there were 45 people using the service.

People's experience of using this service and what we found
People were not always protected from harm. Processes to keep people safe from abuse were not followed robustly by staff. Individual risks were not always assessed appropriately, and safe measures were not in place to manage and mitigate risk.

People's needs were not always assessed accurately or kept up to date to make sure people received safe and appropriate care. Staff supporting people received mandatory training but required a further development of skills to be able to meet people's specific needs. Healthcare advice was not always sought in a timely way, putting people at risk of deterioration in their health. People had a choice of food, but their dining experience was not always positive and dignified.

People's care was not always person-centred, and people were not always supported to maintain interests and hobbies to prevent boredom and to provide stimulation. Plans to support people with their wishes at the end of their life were not always in place.

Staff told us they could raise concerns and be assured action would be taken. However, there was evidence staff had not always raised concerns of potential abuse. The provider and registered manager believed there to be an open culture, but evidence, including investigations held by health and social care professionals did not always show this.

Monitoring and auditing processes were in place to check the quality and safety of the service. These were not always successful in picking up issues that needed action taken.

Some staff had worked long hours which meant people may not always receive good quality care. We have made a recommendation about this.

We were only somewhat assured that people were kept safe by infection prevention and control processes in place. Systems to learn lessons through incidents were not always robust

People were somewhat supported to have maximum choice and control of their lives and staff at times supported them in the least restrictive way possible and in their best interests; the policies and systems in the service somewhat supported this practice. We have made a recommendation about this.

People's prescribed medicines were administered and managed safely.

Some people were supported to maintain and improve their independence.

A suitable complaints process was in place. The provider had not received any complaints. The provider had engaged with people, relatives and staff to keep them updated about important information and gain their views.

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

Rating at last inspection and update
The provider registered with CQC under a new legal entity, on 14 November 2022. The service continued to run with the same nominated individual, management team and staff team under the new legal entity. The last rating for the service under the previous legal entity was inadequate, published on 24 January 2023.

This is the first inspection under the provider's new legal entity.

You can read the report from our last comprehensive inspection under the providers previous legal entity, by selecting the 'all reports' link for Madeira Lodge on our website at www.cqc.org.uk and choosing 'old profile'.

Why we inspected
The inspection was prompted due to continuing concerns received from health and social care professionals about people's care and their access to prompt healthcare. A decision was made for us to inspect and examine those risks.

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

Enforcement and Recommendations
We have identified breaches in relation to the management of risk, keeping people safe from abuse, accurate record keeping, person centred care, dignity and respect, and monitoring and oversight at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will also request an action plan to understand what they will do to improve the standards of quality and safety. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and we will re-inspect within 6 months to check for significant improvements.

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

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

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

We always ask the following five questions of services.

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

# Madeira Lodge

**Detailed findings**

## Background to this inspection

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

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

Inspection team
The inspection was carried out by 2 inspectors on 1 December 2022. One inspector carried out a remote review of evidence on 6 and 7 December 2022 and visited on site again on 8 December 2022.

Service and service type
Madeira Lodge is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Madeira Lodge is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service. We sought feedback from the local authority, including their safeguarding team, commissioners, and professionals who work with the service. As the service had registered as a new legal entity, we had not asked the provider to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

We used all this information to plan our inspection.

During the inspection
We spoke with 4 people who used the service and 4 relatives about their experience of the care provided. We observed the care provided within the communal areas. We spoke with 7 members of staff including the registered manager, operations director, deputy manager, senior care workers and care workers.

We reviewed a range of records. This included 7 people's care records and multiple medication records. We looked at 2 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Inadequate

# Is the service safe?

## Our findings

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

This is the first inspection of this newly registered service. This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

At our last inspection under the registration of the provider's previous legal entity, this key question was rated inadequate.

Systems and processes to safeguard people from the risk of abuse

At the last inspection, of the previous legal entity, we had concerns for people's safety due to serious allegations of abuse and our concerns that staff were not raising concerns. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, of the provider's new legal entity, some improvement had been made, the provider engaged with the local authority safeguarding team. However, we continued to have serious concerns around staff culture and the approach of the management team to concerns raised.

● Staff had received training in safeguarding, and staff we spoke with were able to speak about the different types of abuse and describe how and where to escalate concerns. However, systems and processes in place to support people from the risk of abuse were not followed by staff.
● Safeguarding concerns had continued to be raised with the local authority safeguarding team, by whistleblowers and health care professionals. The provider had carried out investigations where appropriate and as advised by the local authority. The registered manager had investigated one alleged incident, raised with the local authority safeguarding team by a person external to the service. The alleged incident was in relation to how staff had responded inappropriately to a person's episode of agitation. Some staff told the registered manager during the investigation they had witnessed the incident however, they had not raised this with the registered manager as a concern. The lack of reporting by staff had not been a cause of concern by the registered manager or management team during the investigation. There was a risk that incidents of potential abuse may not be recognised, and therefore going unreported, leaving people vulnerable to the risk of abuse.

The provider and registered manager failed to protect people from abuse and improper treatment. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

● People's relatives told us they thought their loved ones were safe living at Madeira Lodge. One relative told us they had been on holiday and felt very comfortable going and leaving their mum as they were confident mum was safe. They also said, "Mum seems happy here and settled in surprisingly quickly." Another relative told us, "I know she's safe here, I see her every day."

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At the last inspection, of the previous legal entity, the provider and registered manager failed to assess the risks to the health and safety of people or do all that was reasonably practicable to mitigate risks. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, of the provider's new legal entity, some improvement had been made, however, we still had serious concerns about the assessment and mitigation of risk.

● Individual risk assessments did not provide sufficient guidance for staff to ensure identified risks were managed well to prevent harm. Some people became frustrated or upset when they were anxious or worried. This was recorded in people's care plans. However, sufficient details were not always included, for example, what the triggers or signs were and how to mitigate risk to themselves or others. For example, one person living with dementia could become aggressive due to their anxiety. The guidance provided did not include what staff must do to keep people living in the service safe at these times.
● One person had deteriorated in health which meant their skin was at risk of breakdown. The person had significant pressure sores which were increasing in number. Health care professionals were treating the sores. The person's skin integrity risk assessment made no reference to how the significant sores were being managed, or the role of staff in the care of their skin. The person's nutrition was poor, however, there was contradicting information in their care plan referring to a good appetite and eating well but also a declining appetite. Staff told us the person ate better at evening time rather than lunchtime, however, moving the person's main meal to the evening had not been considered until we pointed it out to the registered manager. The person had lost a significant amount of weight in a 6 month period.
● One person's care plan stated they were on food and fluid watch which meant their food and fluids must be recorded so their intake could be monitored. The person's fluids were not always being recorded. Over a 1 week period, the person's fluid intake had only been recorded on 1 day. When we questioned this, the registered manager told us the person was not on fluid watch. However, the person's care records clearly recorded their food and fluid intake should be watched and recorded daily. The person was at risk of dehydration as safe monitoring processes were not consistently kept and checked.
● One person who had lost weight was being given milkshake supplements that had not been prescribed. The registered manager said they had them in stock so used them. The shakes had been prescribed for someone else no longer living in the service.
● There were stairgates on each flight of stairs, which were all open during the inspection. Staff told us the stairgates were left open as 1 person had tried to climb over them, creating a risk of injury. A risk assessment was in place, dated December 2018, but did not describe the current situation. A safeguarding alert had been raised by a healthcare professional. When they visited the service there was an incident where the person they were visiting could not be found immediately. They were found to have climbed the stairs unnoticed by staff. The person had epileptic seizures so was at risk of falling during a seizure. The stairgate risk assessment had also not been updated following this incident. The registered manager told us they watched 1 set of stairs near their office and staff watched another flight of stairs. This was not a safe assumption to make as the registered manager and staff were busy and not always in the area.
● One person had lost 5 kgs in weight since August 2022. Their care plan did not reflect the loss, or what was being done to mitigate the risk of further weight loss. The person was at risk of suffering further weight loss as management plans were not in place to prevent the risk of malnourishment.
● Although a process was in place to make sure lessons were learned from accidents and incidents to prevent future occurrences, this was not always used effectively.
● Actions taken post fall were not always described and it was not always clear if the registered manager had reviewed the information in incident records. Care plans and risk assessments were not always

reviewed and updated following an incident. For example, an incident involving verbal or physical aggression, or following a fall.

The provider and registered manager failed to assess the risks to the health and safety of people or do all that was reasonably practicable to mitigate risks. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At the last inspection, of the previous legal entity, the provider and registered manager failed to deploy staff appropriately. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, of the provider's new legal entity, some improvement had been made.

● The provider had now ensured enough staff were on shift overnight and had made sure senior care staff were deployed more effectively throughout the service during the day.
● Some staff had worked long hours without a rest day. One staff member had worked 78 hours over 8 days without a rest day. Another staff member had worked 10 night shifts, 120 hours, without a rest day. People were at risk of receiving poor quality care due to staff not having sufficient rest from working shifts. The registered manager told us they were unaware of the numbers of hours worked, but said this was due to staffing issues at the time and they would ensure this did not happen again.

We recommend the provider seek advice and guidance in how to ensure the safe deployment of staff based on people's needs.

● Relatives told us they thought there were sufficient staff to meet their loved ones' needs.
● The recruitment records we reviewed showed staff were recruited safely. They had appropriate checks of work history, references and Disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Preventing and controlling infection
● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. An open commode pot with no lid was placed on the floor in 1 person's bedroom. The pot was unclean and standing next to the person's clothes hanging on an open rail. Appropriate bins were not used in some bathrooms. Some bathrooms had wire waste-paper baskets and other bathrooms had pedal bins with no lid as the lid was broken. This posed an infection control risk. The registered manager told us they had ordered new bins to replace those that were in inappropriate use.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
People were able to have visitors when they chose. Relatives told us they could visit their loved ones regularly and when they wished.

Using medicines safely
● Medicines were managed safely in line with national guidance and supported by organisational policies.
● Medicines were stored securely in clean, temperature-controlled conditions. A relative told us, "They are on top of her medicines, if I take her home, they give me what is needed."
● Medicine administration records were completed accurately electronically. Medicines were administered by senior care staff who had been trained and assessed as competent. Where people needed medicines through a skin patch the sites were rotated to prevent skin irritation. Where people had medicines 'as required' (PRN), for example for pain relief, protocols were in place and clear.
● Medicines were audited monthly. Medicines requiring additional control were recorded in line with legislation and were checked regularly by senior staff.

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.

This is the first inspection of this newly registered service. This key question has been rated requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

At our last inspection under the registration of the provider's previous legal entity, this key question was rated inadequate.

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

At the last inspection, of the previous legal entity, the provider and registered manager failed to ensure people's care and treatment was accurately recorded and updated to meet their needs and reflected their preferences. This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

At this inspection, of the provider's new legal entity, some improvements had been made, the process of transferring to a new electronic system had been progressed so there was less risk of missed information.

- Assessments used to make sure people received the care they needed were not always up to date and did not always address people's changing needs.
- Assessment tools used to assess people's level of need and risk were not always completed accurately. This meant some people were at risk of not receiving appropriate and safe care. For example, one person's pressure area assessment tool was not fully completed so it was therefore inaccurate. Risks such as loss of weight had not been added. The person had lost weight which meant the correct guidance may not be in place to prevent the risk of pressure sores.
- Clear individual guidance was not recorded in some people's care plans about how staff should support their oral health. Although care plans stated if people needed assistance or reminding, further guidance was not recorded about their individual preferences or needs. For example, if people declined to clean their teeth, what strategies worked to encourage them.
- When we were visiting people's bedrooms, we found 5 people did not have a toothbrush or toothpaste and 1 person had no toothbrush. Another person's dentures were sitting in a cup with dirty water and 2 toothbrushes were in the cup with their heads down in the dirty water. People were at risk of poor oral health which could lead to infection, malnourishment and pain.

The provider and registered manager failed to ensure people's care and treatment was accurately recorded and updated to meet their needs and prevent harm. This is a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to eat and drink enough to maintain a balanced diet

● Although people were referred to health care professionals when they required advice and treatment, referrals were not always timely. One person was becoming increasingly anxious and requiring more support from staff to try to alleviate their anxiety. Staff contacted many appropriate agencies to access support. However, intervention by healthcare professionals could have been sought earlier, when the person's anxiety began to increase, and their mental health started to deteriorate. Risks to the person, other people and staff could have been reduced.

● We saw that evidence of contact with healthcare professionals had improved since the last inspection of the provider's previous legal entity, where this was raised as an area of serious concern. However, there continued to be a delay in requesting advice quickly enough.

● There was conflicting information about when 1 person, who had experienced choking episodes, was referred to the appropriate healthcare professionals for advice and guidance. The registered manager told us they had asked the GP to refer to speech and language therapy (SaLT). However, this was not recorded in the health care records. The person had been visited by a health care professional from the GP surgery in October 2022, during the previous inspection, in relation to the choking episodes. No records had been kept to evidence follow up by the registered manager, until during this inspection, on 5 December 2022.

● We visited 1 person who spent time in their room. Their breakfast cereal had been left on their table without being eaten or cleared away at 11am. The table was unclean and sticky. Over the previous 7 day period, staff had only recorded the person had eaten breakfast twice. One day no food had been recorded throughout the day. The person had a jug of water labelled with the previous day's date. Staff told us they monitored the amounts people drank by how much fluid had gone from their jug. The jug was half full which suggested only half had been drank the previous day. The person had not been given a fresh jug of water/juice during the morning.

● We did not observe a positive dining experience at meal-times. One person was still sat at the dining table after their breakfast, until 11.45 before they were supported to move. Dining tables were not set with cutlery and condiments before people sat down for their meal. People were not given the opportunity to wash their hands before their meal if they wished to do so.

The provider and registered manager failed to ensure people received safe care and treatment. This is a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● Some people ate at dining tables, some in the lounge areas and some people chose to eat their food in their room. We did not have negative feedback about the food, and we saw snacks available through the day.

● People were offered a choice of meals at lunchtime and some people were shown the meal to support their decision-making.

Staff support: induction, training, skills and experience

At the last inspection, of the previous legal entity, the provider and registered manager failed to provide appropriate support, training and professional development. This was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

At this inspection, of the provider's new legal entity, improvements were still needed.

● Although staff had access to mandatory training, they had not had the opportunity to develop the skills to

provide safe care and support in specialist areas.
● Staff were supporting people with challenging and complex needs. They had not received the necessary training to ensure their confidence and consistency in supporting people through challenging times. The registered manager told us the provider was discussing positive behaviour support training with a training provider, but this had not yet been agreed.
● Staff were supporting a number of people living with dementia and complex needs. There had been safeguarding incidents which suggested some staff may not always have the skills to support people living with advanced dementia. Staff had received basic online dementia training. The registered manager told us they were arranging further training for staff and was in the process of accessing this. However, this had not commenced at the time of inspection.

The provider and registered manager failed to ensure staff had the skills and ability to provide safe care. This is a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● Staff had access to mandatory training through an online platform. Some mandatory training was completed face to face, such as moving and handling and first aid.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA , whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

At the last inspection, of the previous legal entity, the provider and registered manager failed to put in to practice the requirements of the MCA. This was a breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

At this inspection, of the provider's new legal entity, some improvements had been made.

● Mental capacity assessments had improved since the last inspection under the provider's previous legal entity. Time had been spent making improvements. The level of understanding in how to evidence best practice in relation to the MCA had improved. However, more work was needed to make sure a consistent approach was used, and people's rights were maintained.
● Some mental capacity assessments provided an evidence-based approach to determining a person's mental capacity to make particular decisions. Other mental capacity assessments were not fully completed, and best interest decision making was not evidenced.
● The registered manager had made new applications for DoLS authorisations and had re applied for those that had expired.

We recommend the provider and registered manager seek advice from a reputable source to ensure the basic rights of people in relation to the MCA are met.

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

● The service had been adapted and added to, with an extension that provided more bedrooms and also more communal space. The new area, including the bedrooms and corridors, was bright and airy. There was a contrast with the older area of the building, which needed attention for the bedrooms to be brought up to equal standards.

● Signage was in place to support people to find their way around. People's bedrooms were numbered and their name on the door which helped them to find their room. Many people were walking around the service, in between areas and knew where they were going.

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.

This is the first inspection of this newly registered service. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

At our last inspection under the registration of the provider's previous legal entity, this key question was rated requires improvement.

At the last inspection, of the previous legal entity, the provider and registered manager failed to ensure care was provided in a caring and dignified way. This was a breach of Regulation 10 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

At this inspection, of the provider's new legal entity, some improvement was evident but we still had concerns in relation to people's dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care

- People were not always treated well or with dignity and respect. Although we felt somewhat reassured and did not have the same level of concerns as we did when we inspected under the provider's previous legal entity, further improvement was needed to the quality of people's care.
- One person had soiled themselves while sitting in a communal area. This was evident to the inspector when they walked into the room, however, staff in the room at the time were unaware until it was pointed out to them. More timely action by staff may have preserved the person's dignity
- Water taps were not working in 1 person's bedroom sink. We told the registered manager about this. Taps in some empty rooms were also not working and some people had been moved to another room because they did not have running water. Lack of timely action to respond to the issues meant some people's lives were disrupted which could cause anxiety and confusion.
- People or their loved ones were not always involved in decisions about their care. Decisions had been made in people's best interest without evidence these had been discussed with relatives. Reviews of people's care did not always involve the person or their loved ones to make sure care met their needs and wishes.

The provider and registered manager failed to ensure care was provided in a caring and dignified way. This is a breach of Regulation 10 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

- One healthcare professional said, "Staff are very friendly and lovely with everyone."
- We saw some caring interventions by staff with people and some staff brought a sense of fun into the

lounge area. Staff were cheerful and friendly. One relative said, "All the girls are lovely, they all help her." One staff member was heard encouraging a person to stand and try do some things independently. The staff member kept encouraging until the person succeeded.

● Staff gave people basic choices through the day, for example, if they wanted a drink, or what meal they wanted at lunchtime. People who could walk around could choose which communal area they chose to sit in.

● A member of staff had a tray of snacks to share out during the afternoon, encouraging people to choose what they wanted. One person had difficulty choosing and started to line up the snacks on the table. They were very happy to see the snacks and the staff member told us the person loved snacks. The staff member could see the person was struggling to make a decision, so took some of the snacks off the tray, leaving less to choose from. The person was then able to choose what they wanted.

Requires Improvement

# Is the service responsive?

## Our findings

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

This is the first inspection of this newly registered service. This key question has been rated requires improvement. This meant people's needs were not always met.

At our last inspection under the registration of the provider's previous legal entity, this key question was rated requires improvement.

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

At the last inspection, of the previous legal entity, the provider and registered manager failed to provide appropriate support in a person-centred way. This was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

At this inspection, of the provider's new legal entity, we still found concerns in relation to people's individual care.

- Care plans did not always provide guidance for staff in a way that was individual or detailed to ensure people had choice and control over their care.
- People's daily records did not accurately describe the care they had received. The electronic system used did not reflect people's day well. This had not been noticed by the registered manager until we pointed it out. One person required 1 to 1 support due to extreme agitation. Their daily record was basic, using standard phrases which were not accurate. One daily account recorded, 'was agitated, was content; in pain, was content'. The person could not have been content if they were in pain or agitated. The record could cause confusion, resulting in care that was not consistent.
- One person's bedroom was sparse with limited furniture and in a poor condition. The room was un-welcoming and no hint of an effort being made to provide a personal space. There were holes in the wall and the space was not clean. When we asked the registered manager about this, they told us the person preferred to have limited furniture and they destroyed any items. However, nothing was written in their care plan that evidenced this, and there was no record of their having destroyed furniture and personal items. The registered manager said they would ensure furniture was introduced into the room and the walls repaired as soon as possible.
- Care plans were not always written in a respectful way. One person's care plan recorded they had 'been known to act like a child around food, and if there is something on her plate she has decided she doesn't want to eat she will refuse her food'. The care plan did not go on to provide guidance to staff how to prevent the situation or what to do if the person refused their meal.

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

● Some people were supported to take part and engage in activities through the day. However, others did not have the same opportunities to engage in activities that would interest them and give them a sense of purpose.
● During the inspection, the activities coordinator worked hard making Christmas decorations to enhance the environment. The activities took place in the new lounge area. Some people were involved in taking part. However, many people were not supported to move from the older lounge area to the newer area to take part. Other activities were not offered that may better suit some people.
● People's activities records did not provide evidence of actual meaningful activity. The tick box activity records included personal care such as hair-brushing as an activity. One person's records showed hair-brushing was completed as taking place most days. However, activities to engage people's minds and prevent boredom such as arts and crafts, singing and film were recorded infrequently. The person had been involved in reminiscence only once in a month and TV only twice in the month. We did not find evidence of people being engaged in 1 to 1 sessions, for example, with people who spent time in their rooms.
● Peoples activities care plans did not provide information about what people's interests and hobbies had been before moving into Madeira Lodge. Being able to follow interests that were dear to people would enhance their experience of living at Madeira Lodge. One person's care plan said they did not join in activities, but they liked to listen to music. The type of music they enjoyed listening to, if there was a time of day they liked to do this and how staff could facilitate this had not been recorded.
● Important information about some people's life and what and who was important to them was not always recorded. One person's record said they had a wife with no further information about their relationships.

End of life care and support
● End of life care plans were limited in the information provided. Plans did not provide individual wishes and those of loved ones, where plans were in place. The information was generic and suggested some areas would be discussed with loved ones at the time of death. A dignified death with the wishes of the person was not fully addressed in care planning.
● One person's health had deteriorated significantly, and they had been identified by health care professionals as nearing the end of their life. The end of life care plan said the family would be approached when the person reached this stage. The care plan had not been updated. There was a risk the person and their loved ones' wishes may not be followed when they were at the end of their life.
● Another person had nothing recorded about their wishes or their loved ones' views about end of life wishes or plans. A record had not been made if it was their wish not to discuss their end of life.

The provider and registered manager failed to provide appropriate person-centred support across all of the areas above. This is a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● People's communication needs were recorded in their care plans. One person did not speak English. The registered manager told us about the efforts they had made with outside agencies to communicate effectively with the person.
● Pictures were used with some people to enhance communication and support understanding. The

registered manager told us they would provide information and documents in formats such as large type or seek advice to provide in braille if it was needed.

Improving care quality in response to complaints or concerns

- The provider had systems and processes to handle complaints effectively. No complaints had been received since the provider changed their legal entity.

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.

This is the first inspection of this newly registered service. This key question has been rated Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection under the registration of the provider's previous legal entity, this key question was rated inadequate.

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

At the last inspection, of the previous legal entity, the provider and registered manager failed to operate a robust quality assurance process to continually understand and have oversight of the quality of the service and ensure any shortfalls were addressed. The provider and registered manager failed to maintain accurate and complete records in relation to the service and people's care. This placed people at risk of harm. This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

At this inspection, of the provider's new legal entity, some improvement had been made but we continued to have concerns about management and leadership and record keeping.

● Staff told us there was an open culture and felt they could raise any concerns with the provider or registered manager and action would be taken. We found this did not happen. Many serious concerns were found at the last inspection of the provider's previous legal entity. At this inspection, of the new legal entity, although we did not find concerns of the same severity, we found the same issues about staff not raising concerns which placed people at risk of harm.
● Staff had not raised an incident of potential abuse with the registered manager. Staff spoke about it only after an external whistleblower raised allegations with the local authority. Staff told the registered manager they were not concerned about another staff member's behaviour. There was the risk that a closed staff culture had developed.
● There were areas of the electronic system that did not work well or were not accurate. When we raised this, the registered manager looked into the issues and contacted the system provider. However, issues had not been recognised before we raised them. The registered manager and staff had gaps in their knowledge which meant accurate information about people was not always available.
● People's care plans and risk assessments did not include the detail and guidance needed to be sure people received care that was personal, reflected their individuality and met their needs. The registered manager had spent time updating records on the electronic system. However, the detail required to ensure consistency in people's care was still missing. We have described how the individual guidance for staff to

provide good quality care in situations such as the end of people's life, during experiences of agitation, or their eating and drinking needs was not sufficient.
● Most staff had long and painted nails. We spoke with the registered manager at the previous inspection about this as it could pose an infection control risk to people. At this inspection the risk remained, and the registered manager did not consider this was a concern.

The provider and registered manager failed to keep accurate records and ensure an open culture. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had engaged independent consultants to review the staff culture and make recommendations. The provider had asked them to meet with individual staff members to provide an external, impartial investigation by gaining staff feedback. A report was shared with the provider. The provider's operations director told us the consultants were available to offer advice and guidance when needed.
● Staff told us the service had improved since the last inspection (under the provider's previous legal entity). One staff member said, "We had a kick up the behind I think. Things are now changing, and staff are more positive, we needed it." A relative said, "I am so happy mum is here and very grateful to them all."
● The registered manager had recently changed the structure of the senior care team and tightened their roles and responsibilities to support her and to ensure accountability. Staff felt positive about the change and thought it would better define roles and responsibilities.
● Relatives told us they were kept informed and updated, for example, if their loved one had a fall, or needed to see the GP.
● Registered persons are required to notify the Care Quality Commission (CQC) about events and incidents such as abuse, serious injuries and deaths. The provider and registered manager understood their role and responsibilities and had notified CQC about all important events that had occurred.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care
● The provider had a process for monitoring the quality and safety of the service. However, completed audits did not pick up many areas that needed improvement.
● Audits completed by the provider's representative did not record the dates of when the operations director visited but recorded the month only. The operations director said they visited at various dates through the month then developed an action plan at the end of the month. This meant it was difficult to ascertain when the issues noted were picked up, so it was not clear if areas that needed immediate attention had been actioned straight away.
● One audit in November 2022 stated the heating and hot water issues had been resolved, however, we found during our inspection these issues were still present. An audit stated all general risk assessments were up to date. However, we found the stair gate risk assessment had not been updated since 2018, even though 1 person at risk of falling was found walking around alone upstairs.
● The registered manager's daily walk about did not highlight any issues found in any area, including the environment, care planning or activities. The registered manager had answered 'yes' to the question, 'is the home free from odours' every day over 2 weeks. However, the operations director monthly visit had highlighted areas to improve in relation to unpleasant odours in the same period and stated immediate action was needed.
● When people had an episode of anxiety resulting in agitated behaviour, the registered manager told us these were not recorded as an incident. This meant this type of incident was not monitored from one month to the next by them, to support prevention.

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

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The provider and registered manager had held meetings with people to ask their views of the service provided. At a meeting in November 2022 people were asked how they rated the care, cleanliness, food and what people liked best about Madeira Lodge. Comments made were positive and people present who were able to offer a view said they were happy. The provider had also held a relatives meeting following the last inspection of their previous legal entity to inform loved ones of serious issues raised within that inspection.
- The provider and registered manager held staff meetings to provide updates, points of discussion, such as improvements needed, and ask for feedback.

Working in partnership with others

- The registered manager told us they were involved in local networks, worked alongside the local colleges and schools and involved in local initiatives.
- People were referred to health and social care professionals, although not always in a timely manner. There were mixed views from these professionals about the engagement, recording and following through of advice given.

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<br><br>The provider and registered manager failed to provide appropriate person-centred support. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br><br>The provider and registered manager failed to ensure care was provided in a caring and dignified way |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider and registered manager failed to assess the risks to the health and safety of people or do all that was reasonably practicable to mitigate risks. |

| 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<br><br>The provider and registered manager failed to protect people from abuse and improper treatment. |

| Regulated activity | Regulation |
|---|---|

| | |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider and registered manager failed to ensure people's care and treatment was accurately recorded and updated to meet their needs and reflected their preferences.<br><br>The provider and registered manager failed to keep accurate records and ensure an open culture.<br><br>The provider and registered manager failed to operate a robust system to monitor the quality and safety of the service provided. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The provider and registered manager failed to ensure staff had the skills and ability to provide safe care. |