Mr Gurpal Singh Gill

Beacon House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Beacon House Nursing Home is a care home that can provide personal and nursing for up to 22 people across two buildings which are connected by a courtyard area. At the time of the inspection there were 16 people living in the home.

People's experience of using this service and what we found
The provider did not ensure that risks relating to the health, safety and welfare of people using the service were appropriately assessed and mitigated.
The administration of medicines was not always managed appropriately. When an incident and accident occurred, lessons were not learned, and appropriate actions were not taken to reduce the risk of reoccurrence.

The provider did not ensure enough staff were deployed to meet the support needs of people using the service. The recruitment processes put in place by the provider were not always followed.

Training had not been completed by all nurses to ensure they were adequately skilled and knowledgeable to meet the specific health needs of people using the service.

We saw there was a lack of interaction and communication between staff and people using the service. People's needs were not appropriately met because the provider did not ensure support was provided in an appropriate manner.

Care plans and other records relating to people using the service did not always provide up to date information relating to the support they needed. Meaningful activities were not being provided for people living at the home to they led as fulfilling a life as possible.

The provider had a complaints process, but this was not always followed to ensure any issues and concerns by people who used the service or their relatives were investigated and appropriate action taken.

The provider had a range of quality assurance processes in place, but these still did not always identify areas where improvement was required. The provider had also failed to make improvements at the service where we had previously identified areas of concerns.

If a concern was raised in relation to the care provider there was a process to investigate any issues to help ensure people were safe. Personal Emergency Evacuation Plans provided sufficient and up to date information to enable people to be evacuated safely from the home in care of an emergency.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported

this practice.

People were supported to access healthcare professionals. Meals were provided which met people's nutritional needs and personal preferences.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 25 February 2019) and we found six breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches relate to person centred care (Regulation 9), need for consent (Regulation 11), safe care and treatment (Regulation 12), premises and equipment (Regulation 15), good governance of the service (Regulation 17) and staffing (regulation 18).
The service was placed in special measures following the July 2018 inspection and remained in special measures following the January 2019 inspection because it was rated inadequate in the key question of 'is the service well-led?' At this inspection we found improvements had not been made and the provider was still in breach of regulations.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection. We have found evidence that the provider needs to make improvements. Please see the all the key question sections of the full report.

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

Enforcement
We have identified breaches of regulations in relation to person centred care, dignity and respect, safe care and treatment, good governance, staffing and fit and proper persons employed.

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

Follow up
The service has been in 'special measures' for the last two inspections. At this inspection the overall rating for this service is 'Inadequate' and the service therefore 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 six 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 may take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service, if we have not already started this process. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not 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

Beacon House Nursing Home

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by two inspectors and a member of the medicines team.

Service and service type
Beacon House Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are 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
We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection-
We spoke with two people who used the service and one relative about their experiences of the care provided. We spoke with the provider and 11 members of staff including the registered manager, two deputy managers, five care workers, the chef, the housekeeper and an activities coordinator. 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 five people's care plans and medicines records for everyone using the service. We looked at five staff files in relation to recruitment and six staff files in relation to supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at the training records and additional information provided following 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 requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management
At our last inspection and at the inspection in July 2018 the provider had failed to robustly 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 was still in breach of Regulation 12.

• During this inspection we saw risk management plans had been developed for identified risk, but these still did not assess the health and safety of people using the service in a comprehensive manner.
• At the January 2019 inspection we saw there were risk management plans for using the stairs for two people which stated they could use the stairs as they could mobilise, but they needed to be supervised when doing so. During the inspection we saw these people walking around the home and accessing the stairs without supervision. At the inspection in June 2019 we saw the risk management plan for these people still stated they required to be supervised which meant staff were not following the management plans or the risk management plans were not practical to minimise the risk of falls, as staff were not available to supervise the people whenever they used the stairs.
• Also, during the January 2019, we saw risk management plans had not been developed for people living with a medical condition, such as epilepsy or diabetes. At this inspection we saw risk management plans had been introduced but these provided general information about the medical condition and did not relate to the person's specific needs. At the June 2019 inspection we saw the risk management plans had not been updated. For example, for the person living with epilepsy their risk management plan did not identify the types of seizures experienced and did not provide guidance for staff as to what they should be looking out for and how to support the person when they had seizures.
• We saw the care plan for one person identified they had a medical condition which made swallowing difficult. There was also an assessment carried out by the Speech and Language Therapy team in January 2019 which identified the person should have thickened fluids and soft food. We saw a malnutrition risk assessment completed on 15 June 2019 which indicated the person did not have problems with chewing and swallowing contrary to other information in the rest of their care plan. This meant the risks for this person had not been assessed based on their support and health needs.
• One person told us their bedroom did not have enough space for them to be moved to their wheelchair using a hoist. So the care workers transferred the person using the hoist to their wheelchair in the corridor which meant the person was being moved when hoisted from their room to the corridor and the other way round when they returned to their room. The person told us they were happy with this, but this practice

increased the risk to the person and was not recorded in their care plan and there was no information about how to help mitigate the risks associated with moving the person when they were suspended from the hoist.
• The provider did not always ensure the environment was safe. During the inspection we saw staff were bolting the fire door which led from the lounge to the conservatory and provided access to the courtyard area at the rear of the home. This meant people had restricted access to escape routes in case of an emergency. We spoke to the registered manager regarding this and the bolt was removed.
• The automatic door closure system was not working on a person's bedroom door and the staff were using a waste bin to prop the door open. We informed the registered manager of this to arrange a repair to ensure the door would close in the event of a fire.
• We also saw paint tins and items for disposal had been placed in an access way between the two buildings which led to the pavement on the road in front of the home. The access way would be used as a main escape route in case of an emergency but due to what was stored in the access way there was increased risk of fire and that people would not be able to use it during an emergency. We raised this with the registered manager and they arranged for the access way to be cleared.
• The provider had a fire evacuation plan for the home which stated all staff should complete fire safety training every six months. From the training records for 48 staff we saw 11 had not completed the fire safety training and 15 staff had not completed the training every six months in line with the provider's policy.
• The records for the daily fire door and exit checks were last completed on 16 April 2019 and the daily fire panel check was last completed on 31 March 2019 which meant the checks were not carried out in line with the provider's procedure.
• We saw support was still not always provided in a safe way. During the previous inspection in January 2019 we saw a person being brought into the lounge in a wheelchair, but their feet were not on foot plates which increased the risk of their feet catching on the carpet. During the inspection in June 2019 we saw the same person being brought into the lounge in a wheelchair and their feet were again not on the foot plates. This meant there was a disregard to the safety of the person.
• We also saw another person who was brought into the lounge in a wheelchair was supported to transfer to an armchair using a walking frame to help them stand. We saw the care workers had not put the wheelchair brakes on so as the person stood the wheelchair moved away from where the person was standing, increasing risk of it not being in the correct position and the person falling.
• At the previous inspection in January 2019 we saw care workers were checking pressure relieving mattresses three times a day, but the form used only indicated if the mattress was working and not if it was at the correct setting for the person. During the inspection in June 2019 we saw daily checks were still being carried out but the care workers recorded if the mattress was working and at the correct setting but there was no indication of what the correct setting should be for the person. Therefore, the care workers could not ensure the settings were correct for the individual.

We found systems were either not in place or robust enough to demonstrate risk and safety was effectively managed. 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.

• Personal emergency evacuation plans (PEEP) were in place for people living at the home identifying how many staff the person required to support them during an evacuation and if the person should be moved to a safe area on the same floor to await the emergency services or be assisted to leave the building.
• At the previous inspection in January 2019 we saw tinned and dried foods had been stored in an external cupboard in a courtyard outside the kitchen. At the June 2019 inspection we saw the food was now being stored in the kitchen.
• We saw there had been some improvement in the cleanliness of the communal bathrooms and toilets with a reduction in the level of mould in the showers and limescale in the toilets.

• In January 2019 we saw the fire door between the lounge and the courtyard was kept open by a hook attached to an external wall and it did not have an automatic closing system linked to the fire alarm system. At the inspection in June 2019 we saw the fire door was no longer maintained open and the fire door could provide appropriate protection in case of a fire.

Using medicines safely
At our last inspection and at the inspection in July 2018 the provider had failed to ensure medicines are managed appropriately. 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 was still in breach of Regulation 12.

• One person had been prescribed a medicine to treat anxiety and to be administered as and when required (PRN) but there was no protocol in place to provide nurses with guidance on when this should be administered. We also noted that nurses were not clear if the person should have their medicines administered covertly. When medicines are administered in a disguised format without the knowledge or consent of the person receiving them, for example in food or in a drink, it is described as covert administration.
• We saw there was guidance for staff to apply topical medicines for people who had been prescribed these, but we saw the type of cream had been changed for four people, but the details had not been amended on the application protocol to reflect the changes.
• Nurses recorded the temperature of the medicine fridge, but they were not resetting the thermometers to provide an accurate reading, for next time they were going to check the temperature.
• We saw the expiry date on the oxygen cylinder was checked daily but equipment's to be used with the cylinder was not checked. We found the 'used by dates' on the airway tube and on a sealed packet of gloves had expired. This meant, if the equipment was to be used to provide oxygen for a person using the service, the equipment could not be used safely.
• Where a person had been prescribed eye drops the medicines administration record (MAR) chart did not indicate in which eye the drops should be administered. We saw the MAR chart and the label on the eye drops for one person which stated apply to affected eye, but it did not clarify which eye was affected. This was also the case with prescribed creams as the area it should applied was not identified.
• We saw two people had been prescribed medicated shampoos which required regular reviews, but the MAR chart and care plan did not identify when a review should take place or when the use of these products should be stopped. This meant nurses could not monitor the use of these products to ensure reviews were carried out to check if they were still required.

We found medicines were still not managed appropriately to ensure they were administered as prescribed. This was a continued breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• During the inspection we reviewed the MAR charts for 15 people and we saw they had been completed clearly when medicines were administered. We checked the stock of a sample of medicines and noted the quantity in stock matched that recorded on the MAR charts.
• Medicines that were no longer required were returned to the pharmacy for disposal and record forms were completed and signed by both parties.

Preventing and controlling infection

At our last inspection and at the inspection in July 2018 the provider had processes in place to manage the risk of infection, but these were not always followed. 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 was still in breach of Regulation 12.

• During the inspection we checked the mattresses in three people's bedrooms by removing the base sheet. We found the mattresses were dirty and stained which demonstrated they had not been cleaned when the bedding had been changed. We also found the bed frames were dirty and where the bed sides were in use the protective covers were also marked and dirty.
• We observed a care worker changing the bedding in one person's room and they placed the soiled sheets on the floor on top of the pillows. The care worker started to replace the bedding and we asked if they had cleaned the mattress and the bed sides. They confirmed they had not. The fact that staff were not following proper infection control procedures and soiled sheets were not transported safely in the home and were placed on the floor meant there was an increased the risk of the spread of infection.
• There were records to show hoists, wheelchairs and the seated weighing scales were cleaned once a week. During the inspection we checked the equipment and found they were dusty and dirty which showed they had not been cleaned regularly.

We found systems for infection control were not robust enough to protect people from the risk of the spread of infection. 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.

Learning lessons when things go wrong
At our last inspection and at the inspection in July 2018 the provider had failed to ensure lessons were learned following incidents and accidents. 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 was still in breach of Regulation 12.

• The provider had a process for the recording of incidents and accidents with the staff recording when an event occurred, but appropriate action was not always taken to analyse the incidents and accidents to help identify trends for action to be taken to minimise the risk of reoccurrence. For example, we saw one person was found on the floor of their bedroom. The incident and accident record stated staff told the person to go to bed and the person had stated someone had pushed them but there was no information about this claim. The person's care plan had not been updated to identify if the person was at risk of falls or if this was part of their behaviour pattern.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. 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.

Staffing and recruitment
• The provider did not ensure staff were deployed in a way to meet the support needs of people using the service. At the time of the inspection there were 16 people living at home, one of whom was in hospital. Eight people required the support of two care workers with personal care and 10 people received assistance

with continence care. The registered manager confirmed four care workers and a nurse should be on duty between 8am and 2pm, three care workers and a nurse between 2pm and 8pm with two care workers and a nurse between 8pm and 8am.
• We reviewed the staffing rota for the period between 1 May 2019 and 21 June 2019 and we saw the staffing levels were regularly below the levels identified by the provider as adequate to provide the levels of care needed. During this period the number of care workers did not meet the stated level for either part or the whole day on 28 days. The rota indicated one care worker was on duty for 22 night shifts between these date which raised concerns as to whether the member of staff has had adequate rest between shifts. The registered manager confirmed the staffing levels shown on the rota were accurate.
• People we spoke with told us they felt there were not enough staff on duty to support them and in the morning some people told us they were left in bed following personal care and not supported to go to the lounge until lunchtime. On the first two days of the inspection we saw that people were not supported to come to the lounge until late morning. On the first day of the inspection we saw the housekeeper had been left to support people in the lounge with no care workers. The housekeeper had not completed any training in relation to supporting people. This meant people may not have received the care and support they wanted or required.

We found staff were not being deployed adequately to ensure people's care needs could be met. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider had a recruitment process, but this was not always followed. During the inspection we reviewed the recruitment records for five new staff members recruited since the inspection in January 2019. The registered manager explained applicants were asked to complete an application form with their employment history and the contact details of two professional references. We saw two references were not always obtained for the new staff member and where references had been obtained they were not from the most recent employer or directly from the employer. For example, the records for one new staff member, who had started to work at the home, showed only one reference, which was in the form of a testimony and pre prepared, had been received even though the contact details to obtain a second reference was provided.
• This meant the provider did not always have information to assess if the new staff member had the appropriate skills and knowledge to provide care in a safe manner.
• We saw one applicant had restrictions on their visa in relation to their ability to work. We saw the applicant's residence permit which stated they could only work 20 hours weekly during term time. We saw the work rotas indicated that the new staff member had worked in excess of 20 hours weekly on a number of occasions. This meant the provider could not ensure the person's employment met the restrictions identified in the work visa.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to ensure the provider had enough information regarding new staff to ensure they could provide safe and appropriate care for people using the service. This was a breach of Regulation 19 (Fit and proper person employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
• People we spoke with told us they felt safe living and receiving care at the home. There was a policy in place for investigating and responding to any concerns raised about the care provided. During the inspection we saw the records for safeguarding concerns that had been identified since the last inspection in January 2019 and these contained relevant information regarding the incidents and included notes of investigations.

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

Staff support: induction, training, skills and experience

At our last inspection and at the inspection in July 2018 the provider had failed to ensure staff received appropriate training to enable them to fulfil their roles. 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 was still in breach of Regulation 18.

• At the inspection in January 2019 we saw three of the eight nurses which could work at the home had completed training during 2018 in relation to the management of a Percutaneous Endoscopic Gastrostomy (PEG) as there was one person using the service who received their medicines and nutrition in this way. A PEG is a way of introducing food, fluids and medicines directly into the stomach by passing a thin tube through the skin and into the stomach.
• At the inspection in June 2019 we looked at the training records and the deputy manager confirmed PEG training had been completed with some of the nurses. The training records showed six of the 12 nurses who could work at the home had completed the training. This meant a nurse who had not completed the specialist training in PEG management may be the nurse on duty at the home.
• At the time of the June 2019 inspection the registered manager confirmed one nurse of the 12 which could work at the home had their competency assessed in relation to administering medicines. The provider's medicines administration policy stated that the competency of staff administering medicines should be assessed by a pharmacist. This meant the provider could not ensure medicines were being administered by staff who had been assessed as competent to manage medicines.
• The registered manager confirmed all new staff completed a three-day induction to the home with shadowing an experience staff member before they started to work but we saw the induction records for three new staff had not been completed. The records for one staff member stated their induction was in May 2019 but the form had not been completed to demonstrate their understanding of the care required at the home.
• The registered manager told us they aimed to undertake two supervision meetings per year with all staff and an annual appraisal. We looked at the supervision records for six staff members and saw not all of them had completed a supervision with their line manager since the last inspection in January 2019, a period of about six months.
• The supervision record showed four staff members had completed a supervision meeting since the

January 2019 inspection. There were only two appraisals recorded in 2019 and the registered manager explained they were planning to complete appraisals for all staff later in the year.

We found no evidence that people had been harmed however, nurses who could be placed on the rota to work at the home had not completed training to provide specialist care to meet the need of a person using the service and staff did not always receive appropriate support. This placed people at risk of harm. This was a continued breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• We reviewed the training records relating to moving and handling, infection control, health and safety, Deprivation of Liberty Safeguards (DoLS) and safeguarding. These courses had been identified as mandatory by the provider. The records indicated the majority of care workers and nurses had completed these courses since the last inspection. The deputy manager told us they had recently qualified as a moving and handling trainer and was ensuring care workers and nurses had completed their training.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the DoLS. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

At our last inspection the provider did not always ensure people were supported to consent to their care and mental capacity assessments were not carried out to assess people's ability to consent to specific aspects of their care. This was a breach of regulation 11 (Consent to Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found some improvement had been made and the provider was no longer in breach of Regulation 11.

• We saw some people had been assessed as having capacity to consent to their care, but the care plans stated the person's relatives were to be contacted to consent to the support being provided by signing the care plan. For example, we saw the care plan for one person included a mental capacity assessment which indicated they were able to consent to all aspects of their care. The relatives contact sheet stated that the person's relative needed to be asked to sign the consent to care form. There was no record in the care plan to indicate if the person had requested their relative to sign on their behalf. We discussed this with the registered manager who confirmed they would review care plan consent.
• A mental capacity assessment was completed if it was felt a person may not have capacity to consent to aspects of their care. A mental capacity assessment had been carried out for specific decisions such as use of bedrails, personal care, medicines and use of a lap strap when using a wheelchair. Best interest decisions were also recorded when it was identified the person was unable to consent to that aspect of their care.
• We saw there was a record sheet showing when a DoLS application had been made and the local authority were contacted every three months by senior staff at the home to check to progress of the application.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• At the time of the inspection there had been no new admissions to the home since the previous inspection in January 2019, so we were unable to check on recent assessments of people's needs. We saw assessments of people's care needs had been completed for people who had moved into the home prior to the inspection in July 2018.

Supporting people to eat and drink enough to maintain a balanced diet
• People we spoke with told us they were given choices of food and they were happy with the food provided during the week which they felt was good and they enjoyed their meals, but the food provided at the weekend was "Really poor" and the chef had ''Gone to a cookery school where they just use oil.'' One person commented the chef on duty during the week knew the person well and made sure they had the food they liked and wanted.
• We saw the menu contained a range of options to meet people's varied dietary needs including Asian food options. The chef told us they checked with each person at the home every day for their choice off the menu or if there was something specific they preferred to eat. During the inspection we saw one person had told the chef they wanted a specific meal that was not part of the menu that day and the chef ensured that meal was provided at lunchtime for the person.
• The chef told us they sat in on assessments carried out by the speech and language therapy team, so they could get direct information on the consistency and thickness of food the person required. The chef also took part in staff handovers, so they were aware of any changes on people's nutritional needs.

Adapting service, design, decoration to meet people's needs
• Since the last inspection in January 2019 there had been some improvements made around the premises but we saw people's bedding was ripped and did not match. The cupboards and wardrobes in some of the bedrooms were in need of repair and we saw there was a crack in the wooden bed rail which was located on the side of the bed a person used to get out.
• In people's bedrooms, where a television had been fixed to a wall, the angle meant the person could not sit comfortably to watch. For example, the television in one person's was positioned on the wall at an angle which meant the person had to twist to see. The person told us it could be painful.
• There were window restrictors in place, but we saw some of the bedroom window latches were broken which meant they could not be opened to allow air flow, particularly if the weather gets warm.
• We saw that since the previous inspection in January 2019 the provider had started a redecoration programme around the home. The communal areas had been painted and we saw bedrooms were also being redecorated.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
• People were supported to access their GP and other healthcare professionals. We saw copies of the notes following GP visits as well as assessments, letters and discharge information as part of people's care plan.
• The nurse told us the GP visited the home once a week and whenever required. There were regular reviews of each person to monitor their health needs.
• During the inspection the nurse told us that when a person is transferred to another service, such as a hospital, a copy of MAR chart and details of person's relatives is sent with the person. A form is completed which contains the main details about the person when transferred. This helped to ensure healthcare professionals had the necessary information to help treat the person.
• We saw referrals had been made to other professionals including the wheelchair service and occupational therapy to identify if people required any specific equipment and to help ensure that this is provided.

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 now remained the same. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

• During the inspection we saw there was a lack of interaction and communication between staff and people using the service. Staff members walked through the lounge but did not interact with people. Staff also discussed the care provided to people using the service in front of people sitting in the lounge. We saw one person brought to the lounge and given a drink then during the following hour three members of staff spoke briefly to the person with one staff member sitting next to them completing paperwork but not acknowledging the person.

• Care was not always provided to people in a caring and considerate manner. During mealtimes we saw people were given both their main course and pudding at the same time which meant food went cold before people could eat it. For example, we saw, where care workers supported people to eat in their bedroom, the meals were put on a trolley for everyone to be supported. While care workers supported two people on one floor to eat their lunch the meals for two other people were left on a trolley in the corridor. Both the main course and pudding were hot so by the time care workers assisted the people on the next floor the food was starting to get cold. People eating in the lounge were also given both their main course and pudding at the same time which meant food went cold.

• We saw one care worker supporting two people to eat at the same time which meant the care worker sat between the two people facing them and had a spoon in each hand. They then supported both people simultaneously to eat their lunch. This meant people were not being supported in a manner that maintained their dignity and met their individual needs.

• Care workers provided drinks before the meal but did not give the person a choice. We saw one care worker was supporting a person to eat and they put down the spoon for the main course and started giving the person their pudding with no information to let them know the change of food or offer them a drink.

• We saw people were generally able to be as independent as they wished and were able to eat their lunch at their own speed, but we saw one person spending almost an hour eating their meal, but staff did not encourage them or identify that their food was cold so they could rewarm it.

• Care plans identified people's religious and cultural needs. The registered manager confirmed there were regular visits to the home by members of a local church and they spoke with everyone at the home. We asked the registered manager if the people whose chosen faith was not Christian had been asked if they wanted to speak with religious representatives from their faith. The registered manager told us this had not happened and at the time of the inspection there were no visits from any other faith groups. People we spoke with told us they were not supported to access their faith community. There was a lack of support to visit the Gurdwara for people who had specifically requested they wished to make regular visits to the

Gurdwara.

People privacy and dignity was not maintained when care and support were provided. This was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to express their views and be involved in making decisions about their care
• During the inspection we saw only one of the care plan we looked at had been signed by the person using the service or, if the person was unable to consent to their care, by a relative to confirm they had agreed to the planned care.
• Staff were not given time to provide support in a compassionate and personal way due to the number of staff scheduled to work and the amount of care activities they were expected to completed during each shift.

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 now remained the same. This meant people's needs were not always met.

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

At our last inspection the provider had failed to ensure people's care plans and support was provided in a person-centred way based upon their wishes and preferences. This was a breach of Regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of Regulation 9.

• People's care was not planned or delivered in a consistent way. During the inspection we saw the medicines section of the care plan for one person indicated they had their medicines covertly administered. When medicines are administered in a disguised format without the knowledge or consent of the person receiving them, for example in food or in a drink, it is described as covert administration. We spoke with a nurse on the first day of the inspection and they stated no medicines were administered covertly but a second nurse stated they were. This meant the information provided to staff in relation to how this person's medicines should be administered was not accurate and there was no consistent understanding in relation to the person's care needs.
• We also saw a behaviour record chart had been completed for this person as sometimes they behaved in a way that could challenge staff. The care plan did not provide any guidance for staff on how to support the person when they became stressed for example it did not identify what could trigger the person's behaviour and what staff could do to reduce the risk of this happening and how they should support the person if they do become upset.
• The nurse on duty completed the records of care provided at the end of each shift for each person. We saw these records were focused on the care tasks completed and if medicines were administered but these did not always provide information in relation to the outcome of the care the person received. For example, we saw the records of care for one person which indicated they had experienced five days without a bowel movement, but the records for the previous five days indicated the nurse had administered laxatives but there was no indication if these were effective. This meant the records did not provide accurate information relating to the outcome of the care provided by staff and whether people were being adequately monitored.

The provider was not ensuring people received care and support in a person-centred way based upon their wishes and preferences. This was a continued breach of Regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• During the inspection we saw a new format for the care plans had been introduced which included possible risks, and outcome, how people wanted their care provided and how staff can support the person to receive the care they needed.

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;

At our last inspection the provider had failed to ensure activities were provided for people living at the home were meaningful and interesting. This was a breach of Regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of Regulation 9.

• During the previous inspection in January 2019 we identified that there was a lack of meaningful activities organised and people were not supported to maintain links with their community. During the inspection in June 2019 we saw there were no planned activities for people at the home. We spoke with two people and a relative about activities and they told us there wasn't really anything to do or to join in with. One person said that they wanted to go out to the Gurdwara but that this had not happened yet. They told us they had been told they would be going to the Gurdwara by a staff member later that day, but they were then told they were going for a walk instead and they were away from the home for 15 minutes. People who required the support from staff to access activities outside the home were not given that support so had restricted access to activities both inside and outside the home.

The provider was not ensuring meaningful activities were provided to people and they were supported to access the community. This was a continued breach of Regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support;

At our last inspection the provider had not identified people wishes as to how they wanted their end of life care provided. This was a breach of Regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
At this inspection not enough improvement had been made and the provider was still in breach of Regulation 9.

• We saw there was a section in the care plan to identify the person's end of life wishes but we saw this had only been completed in one of the care plans we looked at.
• The training records indicated that four nurses and three care worker had completed training in relation to palliative care.
The provider continued to fail to identify people's end of life care wishes. This was a continued breach of Regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

At our last inspection the provider had failed to ensure information was provided in an accessible format to people according to their needs. This was a breach of Regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of Regulation 9.

• During the inspection we asked the registered manager if information provided for people for example, care plans, policies and signage, was provided in a format suitable for people's communication needs. The registered manager confirmed information was not provided in an appropriate format to meet people's communication needs. People living at the home spoke a number of languages with some people that did not speak or understand English and there were care workers that also spoke these languages, so they were able to communicate verbally.
• Signage around the home was a combination of pictures and words but these were also in English. This meant it may have been difficult for some people to understand the signage.

The provider continued to fail to ensure information was provided in an accessible format for people using the service. This was a continued breach of Regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
• The provider had a complaints procedure, but this was not always followed as either the complaint was not investigated fully, or the actions identified following an investigation were not completed and recorded.
• During the inspection we reviewed the complaints received since the last inspection in January 2019 and we saw where a complaint had been raised not all the elements of the complaint had been appropriately investigated and responded to.
• Where further action had been identified as part of the investigation or response to the complaint, there was no evidence that this has been completed. For example, we saw actions including the provision of additional supervision or training to staff members, were identified but there were no records of any supervision or training taking place.

Complaints had not always been investigated appropriately, action completed, and lessons had not been learned to reduce the risk of reoccurrence. This placed people at risk of harm. This was a breach of Regulation 16 (Complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 now remained the same. 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.

Continuous learning and improving care

At our last inspection the provider had failed to ensure their quality assurance processes provided appropriate information to enable them to identify areas for improvement. 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 was still in breach of Regulation 17.

•The service was rated inadequate and placed in special measures following the July 2018 inspection. At the January 2019 inspection the rating of the service improved to requires improvement but as it was rated inadequate in well-led, it continued to be in special measures. During this inspection we saw some improvements had been made but these were not significant enough and we also identified two new breaches of regulations. This demonstrated that the provider's management structure and governance arrangements had been ineffective in making the necessary improvement within the timeframe that the service has been in special measures.
• We saw the provider had a range of audits in place, but some of these had not been completed since May 2019. Monthly checks were carried out on the water temperature in bedrooms and bathrooms, but this was last completed on 1 May 2019.
• The environmental audits relating to maintenance were last completed on 1 May 2019 with minor issues identified but there was no record of actions being taken to resolve them.
• We saw an audit of the care plans had been carried out on 15 and 16 May 2019 which identified areas where information needed to be added or amended to provide accurate information regarding the care required by each person. The audit form included a list of actions required in relation to each care plan with a date for these actions to be completed but there were no records to show these had been completed.
• We saw the last infection control audit on file was dated 3 January 2019. There was a record that the audit had been completed monthly until 1 May 2019 but there were no completed audit forms or action plans to follow on from the audits to demonstrate this had occurred.
• There was a communal area checklist audit which took place on 1 May 2019 and had a summary of actions needed which included painting, fixture and fitting repair and curtain/blind replacement. There was no record to say whether this work was completed or not, but we did observe redecoration and building work were ongoing around the home, so the issues were being addressed but we could not be sure if the action plan was being met according to the identified timecales.

The provider had not ensured their quality assurance processes provided adequate information to identify where action was required for improvement. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
• There was a registered manager in post at the home who was supported by a senior team. Staff told us it was sometimes unclear who was responsible for which aspects of running the service for example staffing rotas and ensuring adequate staffing levels.
• At the time of the inspection there was no clinical lead in post at the home to provide clinical support for the nurses. This meant the nurses did not have an appropriate support to ensure they provided care in line with best practice.

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
• We received mixed feedback from the two people using the service and a relative we spoke with about the quality of service provided in the home. One person felt there were some good staff members on duty and if they had any concerns they could raise them with the management but everyone else said they felt there was a lack of staff and appropriate care was not always provided to meet their needs.
• Staff we spoke with told us they were supported by the registered manager, but whilst they enjoyed supporting the people living at the home they felt the home was not well run and appropriate care was not always provided as they were short of staff and were not provided with appropriate resources to meet people care and support needs.
• Their comments included ''Everything is good here apart from the weekends when we are short staffed'', "You cannot give proper care and I am not satisfied. There is no time to take time with the residents" and ''The manager is good. He tries to solve our problems, but he can't do everything, and the owner does not really help but what can I do.''
• During the inspection we did not see a culture that was supported by strong values such as integrity, excellence and respect, We saw staff speaking about other staff and people using the service in communal areas so others could hear the conversations. For example, the staff spoke about people across the lounge in front of other people and they also discussed their views about other staff in communal areas, and other people were able to hear the conversation.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• The registered manager told us they spoke regularly with people using the service to get their views on the service. They also confirmed they met with staff regularly to get their feedback

Working in partnership with others
• The registered manager and the deputy managers had been working closely with the local authority and Clinical Commissioning Group to monitor the quality of the care provided, identify areas for improvement and how these could be implemented. The service has been rated inadequate since the inspection in July 2018 and actions identified through this joint working have failed to develop into improvements in the service.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person did not ensure the care and treatment of service users was appropriate, met their needs, reflected their preferences and was designed to meet people's needs by following healthcare professional advice. Regulation 9 (1) (a) (b) (c),(3)(a)(b)

The enforcement action we took:

We took enforcement action to cancel the registration for this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered person had not supported the autonomy, independence and involvement in the community of the service user. Regulation 10 (2)(b)

The enforcement action we took:

We took enforcement action to cancel the registration for this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not ensure care and treatment was provided in a safe way for service users. The risks to health and safety of service users of receiving care and treatment were not assessed and the provider did not do all that was reasonably practicable to mitigate any such risks. The registered person did not ensure the proper

and safe management of medicines.

The registered person the premises used by the service users was safe to use for their intended purpose and are used in a safe way.

The registered person did not assess the risk of, prevent, detect and control the spread of infections.

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

The enforcement action we took:

We took enforcement action to cancel the registration for this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have an effective system to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. Regulation 17 (1)(2) (a)

The enforcement action we took:

We took enforcement action to cancel the registration for this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered person did not ensure recruitment processes were operated effectively to ensure that persons employed were of good character and suitably qualified and experienced. Regulation 19 (1) (2)

The enforcement action we took:

We took enforcement action to cancel the registration for this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person did not ensure sufficient numbers of qualitied, competent, skilled and experienced people were deployed in order to meet the needs of people using the service. The registered person did not ensure people received appropriate training and support necessary to

enable them to carry out their duties.

Regulation 18 (1) (2) (a)

The enforcement action we took:

We took enforcement action to cancel the registration for this location.