Almondsbury Care Limited

Belmont House Nursing Home

Inspection report

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Date of inspection visit:
06 December 2021

Date of publication:
18 May 2022

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
Belmont House Nursing Home is a residential care home providing personal and nursing care. The service can support up to 40 people. At the time of this inspection there were 20 people living in the service. Though the service was over three floors only the ground and first floors were currently in use. Some of these people were living with dementia or were receiving care in bed.

People's experience of using this service and what we found
Many people were not able to tell us verbally about their experience of living at Belmont House Nursing Home. Therefore, we observed the interactions between people and the staff supporting them.

We last inspected the service in October 2021. At that time, we had concerns regarding the management of the service and the service was rated requires improvement. Since that time the management situation has not improved. Before this inspection we were aware the previous two managers had left, and the company's operations manager had been overseeing the service. However, they left their post before this inspection started. On the first day of our inspection a new manager had started and they, were being supported by the area manager. Within a few days of this inspection both the new manager and area manager had left the service.

There remained a lack of consistent management of the service since December 2019. The senior management had also changed during this period. Some improvements had been made at the October 2021 inspection. However, since the departure of the operations manager who was overseeing the service at that time there has been a deterioration. Systems and processes had not been completed or updated as required. Systems had frequently been changed and not effectively implemented or embedded.

At the last inspection, October 2021, it was noted that the high use of agency staff had improved. However, only two qualified nursing posts remain employed by the organisation, one nurse on days and one on nights. The remaining qualified nursing post continued to be covered by agency nurses. We received information of concern before and during the inspection, which stated that on some shifts there had been insufficient care workers and qualified nurses to cover all shifts. This had the potential to put people at risk due to lack of knowledge of the service, residents and systems.

At our last two inspections we found many staff had not completed areas of basic training. At this inspection we found some staff were still required to complete basic training, including Personal Protection Equipment (PPE). Staff told us they did not feel safe with the staffing levels on some days. Regular audits had not always been completed since the departure of the last manager.

People were supported by a staff team that were caring. However, people did not always receive care in line with their care plans. Plans were not always reflective of their current needs. People's care was not always delivered in line with their choice or preference.

The service had an activities coordinator however, some staff felt more suitable activities could be introduced.

Improvement was needed to make sure people's health and quality of life was maintained by effective use of medicines. Support plans had not always been updated to include the monitoring of people's needs, including behaviours which may challenge the service.

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 1 December 2021) and there were breaches of regulation. The provider had not completed an action plan after the last inspection, this was due in part to the manager, operations manager and area manager all leaving the company and to no consistent oversight by any senior management from the company. At this inspection not enough improvement had been made and the provider was still in breach of regulations.

Why we inspected
We carried out an unannounced inspection of this service on 12 October 2021. Breaches of legal requirements were found. We undertook this focused inspection due to receiving information of concern and also to check that service now met legal requirements. This report covers our findings in relation to the key questions Safe, Effective, Caring, Responsive and Well-led which contain those requirements.

We have found evidence that the provider needs to make improvements. Please see the Safe, Effective, Caring, Responsive, and Well Led sections of this full report.

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 could respond to another COVID-19 outbreak.

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

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service.

We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safeguarding, staffing, staff training, medicines, premises, dignity, consent, person centred care, infection control and good governance at this inspection.

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

We will request an updated action plan for the provider to understand what they will do to improve the standards of quality and safety. The provider will continue to submit monthly reports as outlined in the imposed conditions on the providers registration. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this 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? 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**

Belmont 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.

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
Three inspectors including a member of the medicines team, carried out this inspection.

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

The service did not have a manager registered with the Care Quality Commission. This means that the provider is 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 inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from professionals who work with the service.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We used all of this information to plan our inspection.

During the inspection-
We spoke with three people who used the service about their experience of the care provided. We spoke with seven members of staff. This included the newly appointed manager, area manager, care staff, nurses and auxiliary staff. We received information from one professional.

We reviewed a range of records. This included four people's care records, and eleven medication records. We looked at two 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.

At the last inspection this key question was rated as requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

At our last inspection in October 2021 we found some improvements had been made. However, since the departure of a manager and area manager the service had deteriorated. At this inspection we found the provider in breach of regulation 9, 10, 11,12, 13, 15, 17 and 18. Therefore the rating has deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

At our inspection in May 2021 we found the provider had failed to ensure that care and treatment had not been provided in a way that includes acts intended to control or restrain a person that was not necessary. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment).

At our inspection in October 2021 we found improvement had been made and the provider was no longer in breach of this regulation.

During this inspection things had deteriorated. The provider had failed again to ensure that care and treatment had not been provided in a way that includes acts, intended to control or restrain a person that was not necessary. Not enough improvement had been made at this inspection and there was a repeated breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At a previous inspection, February 2021, we received information of concern that some staff were using restrictive practices. The manager employed at that time confirmed no staff at the service were using these practices. However, during the inspection in May 2021 it was recorded in the home's safeguarding folder that an alert had been made on the use of 'safe hold' practices for one person, while carrying out personal care. A DoLS application had not been made to support the use of this practice. During this inspection we were informed by four staff members, and recorded information confirmed this, that one person, in order to carry out full personal care on this person that four staff working together had to, 'hold him down.'

●The provider was again under the local authority's whole home safeguarding procedures. Input and monitoring were regularly provided by the local authority, due to concerns in the service and how the service was managed and overseen by senior management. In particular with the sudden departure of the most recent manager, who only remained in post for three days and had started on the first day of our inspection. Also, the departure of the area manager the same week. Since our inspection in May 2021 the service had lost two senior operations managers and three service managers.

●The number of staff requiring training in safeguarding adults and equality and diversity had increased since the last inspection. Currently 39% of staff needed to complete safeguarding training and 52% needed

to complete equality and diversity training.

The provider had failed again to ensure that care and treatment had not been provided in a way that includes acts intended to control or restrain a person that was not necessary. Not enough improvement had been made at this inspection and there was a repeated breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Safeguarding policies and procedures were available for staff to access.

Using medicines safely

●Improvements were needed to make sure people were given their medicines to treat their physical and mental health.
●Medicines administration records (MARs) were not always accurate. Registered nurses administered medicines. A nurse was observed to sign the MAR before giving a medicine, which is not best practice. The time when medicines were given was not accurately recorded on the MAR. For example, medicines seen to be given to people after 11am were recorded on the MAR as 9am. There were some gaps on MARs when medicines had been given but not signed for.
●Some people were prescribed medicines to be taken when required. People with dementia might not have been able to ask for a when required medicine. There was some guidance to help nurses make consistent decisions about whether to give a when required medicine. But this guidance was not in place for all when required medicines. Guidance for this was not person-centred and did not describe when an individual person might need a medicine to be given. For example, pain relief or medicines to reduce distress or anxiety. Nurses did not record the reason for giving a when required medicine or whether it was effective.
●Some people living in the home had been assessed as not having the mental capacity to make decisions about whether to take their medicines. It had been decided that it was in their best interest to give medicines covertly as agreed by GP's and hidden in food or drink. However, nurses were not attempting to give medicines covertly to one person. Instead the MAR showed that medicines were regularly refused. This meant the person did not receive medicines that might have improved their wellbeing and quality of life and reduced the likelihood of physical restraint by staff. Another person did have their medicines given covertly but there was no record of how to do this and the MAR did not indicate which doses had been given covertly.

●Guidance and records were not available to support the safe administration of external medicines, such as creams and lotions. Care staff did not have guidance on where creams should be applied or how much. Staff recorded that creams had been applied in the daily notes, but this did not include what specific creams had been applied or where.

The provider had not ensured the proper and safe use of medicines. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were ordered, stored and disposed of safely.

Staffing and recruitment

At our last inspection the provider had failed to ensure sufficient employed qualified staff were available to provide consistent care. This was a breach of regulation 18 (Staffing).

We found at this inspection the situation remained the same. Not enough improvement had been made at

this inspection and there was a repeated breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The majority of the clinical staff working at the home were not employed by the service and worked for an agency. The service only had one qualified nurse employed to cover all days shifts and one employed nurse to cover all night shifts. The remainder of qualified nurses were from an agency. Having only agency nurses on shift had the potential to put people at risk. This was due to lack of knowledge of the service, residents and systems and therefore people might not receive consistent care. One nurse currently employed, worked in excess of their normal working hours to cover shifts due to the lack of agency nurses being deployed in the service.
● Staff remain concerned about the staffing levels. Staff told us a high number of people required the support of two staff or one-to-one observation. This was due to either being at high risk of falls or displaying behaviour that could be challenging. Comments included; "We are all fed up of the change of management and short of staff." While another said; "We need more senior staff and staff who will stay!"
● Staff recognised that the lack of consistent leadership had impacted on the service's performance. Comments from staff included; "People have very high needs at the moment and there isn't enough staff to manage them." Another said; "Staff remain burnt out and are struggling at times when short of staff or too many agency staff on duty who don't know people" and "One person doesn't like young female staff to assist them. But there's no choice for him." Other comments received included; "Staff don't feel safe with X as they don't know them, and they can throw things and hit out. Staff are frightened so don't go into them, so sometimes four staff go in which makes it worse." "The continuing change of managers and senior managers really don't help the situation." Professionals continue to say that the lack of consistent managers in post has caused communication and consistency difficulties. Lack of consistent management and consistent staffing levels has an impact on staff morale and had the potential to have an impact of people safety. At times since the last inspection the staffing levels had dropped below satisfactory levels.

The provider had failed to ensure sufficient employed qualified staff were available to provide consistent care. This is a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Recruitment practices were thorough and included pre-employment checks from the Disclosure and Barring Service (police), undertaken before new staff started work.

Assessing risk, safety monitoring and management

At our last two inspections the provider had not ensured the equipment used to keep people safe had been adequately monitored and maintained. This was a breach of regulation 12 (Safe Care and Treatment).

We found some improvements had been made in our October 2021 inspection. For example, audits had been completed to ensure people's pressure relieving mattresses were at a safe pressure level.

However, at this inspection and since the departure of the last manager not all checks and audits continued to be carried out or recorded consistently. Not enough improvement had been made at this inspection and there was a repeated breach of regulation 12 (Safe Care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At the previous inspection it was noted that an electrical installation certificate required action. This had now been actioned.

● People were not always protected from risks associated with their health, safety and welfare. People's needs, and abilities were not always individually assessed prior to moving into the service.
● People's care plans did not contain sufficient information for staff to be able to support people with their behaviours and were not updated after incidents occurred. This had the potential to place the individual and others at risk of harm. For example, it was recorded that one person had been attended to by four staff members and had been 'pinned down'. The care plan did provide staff with sufficient information on how to support this person appropriately with their personal care needs. However, this information was not adhered to. One staff member said; "Staff are scared."
● Weekly fire alarm testing had not always been carried out as required. Other checks, for example, water temperatures, had not always been carried out consistently, in part due to no consistent manager or senior manager overseeing at the service.
● The service's action plan provided at the inspection in May 2021 reported other areas of the premises remained unsafe. For example, 'Fuse box area unsafe- residents have access to them' and 'Fire door has shrubbery growing over it.' A tour of the premises showed some areas have now been made safe. However, other areas needed work. For example, in the outside areas rubbish had been dumped.
● Where people experienced periods of distress or anxiety, due to living with dementia, staff were observed to respond effectively. However, during our observations it showed staff were not always observing people as their care plans stated. For example, one staff member was allocated to observe one person every 15 mins. This staff had worked for over three hours since they had begun their shift, but due to staff shortages had not yet had any contact with this person.

The provider had not assessed the risks to the health and safety of people receiving care. The provider had not ensured the premises used by people are safe to use. This was a continuous breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

All our inspection in May 2021 the provider had not taken all necessary action to protect people from infection. This was a breach of regulation 12 (Safe Care and Treatment).

At our inspection in October 2021 we found enough improvement had been made and the provider was no longer in breach of this part of regulation 12.

At this inspection we once again found issues of concern over the prevention and control of inspection. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were somewhat assured that the provider was using PPE effectively and safely. Currently 74% of staff had completed PPE training.
●We were somewhat assured that the provider was meeting shielding and social distancing rules. Staff did not always adhere to social distancing within the home and were observed sitting next to people not wearing face masks.

The provider had not taken all necessary action to protect people from infection. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● 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.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Learning lessons when things go wrong

●Since the resignation of the last long-term registered manager who left the service in December 2020 there has had seven temporary managers. There was clear evidence of managers consistently not performing well, therefore poor management retention.
● There was no evidence the service reflected and learnt from issues and incidents when things went wrong. There was limited use of systems to record and report concerns. When things went wrong reviews and investigations were not sufficiently thorough.
● Where changes in people's needs or conditions were identified, prompt and appropriate referrals to external professionals had not always been made. For example, people had not been referred to a behavioural team for support in managing one person's needs, that could be seen as challenging.

Requires Improvement

Is the service effective?

Our findings

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

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

Staff support: induction, training, skills and experience

At our inspection in May 2021 we found the provider had not ensured all staff received appropriate support, training, professional development, supervision and appraisal, as is necessary to enable them to carry out the duties they are employed to perform. This was a breach of regulation 18 (Staffing).

At our October 2021 inspection we found that though improvements had been made not all training had yet been completed. The provider remained in breach of Regulation 18 Therefore, the provider remained in breach of Regulation 18 (staffing).

At this inspection we found additional staff had not completed training and professional development or received appropriate support. Not enough improvement had been made at this inspection and there was a repeated breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We reviewed the training matrix which showed little or no improvement in staff having completed training and induction. One staff member said; "Not all (staff) are trained properly."
- There were systems in place to monitor training. However, though improvements had been made at the inspection in October 2021 some staff training still required completing. For example; 29% of staff needed to complete dementia awareness training, 14% needed to complete end of life training and 26% needed to complete infection control training. The training matrix also showed that 34% needed to complete PPE training and 48% were required to complete fire awareness training. This could place people at risk of harm because staff might not have the right skills to fulfil their roles.
- Staff informed us they had little or no opportunity to discuss their individual work and development needs, including one to one supervisions or annual appraisals. This, they felt was due to inconsistent management in post.
- Staff continued to find the inconsistent management and senior management role for the company difficult. One commented; "It's been constant change. We never get to know them before they leave."

The provider had not ensured all staff received appropriate support, training, professional development, supervision and appraisal, as is necessary to enable them to carry out the duties they are employed to perform. Not enough improvement had been made at this inspection and there was a repeated breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● At this inspection the service was using both the ground floor and first floor for people. The third floor was being used to accommodate staff from overseas until appropriate accommodation could be found elsewhere. Therefore, the planned upgrade of facilities on the top floor remained on hold.
● The environment still required some upgrading. We found outside areas strewn with rubbish and internally there was heavily stained flooring.

The provider must ensure the premises used by people are properly maintained. This was a continuous breach of Regulation 15 (Premises and Equipment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's rooms were decorated with some personal belongings to ensure they felt comfortable with familiar items around them.

Staff working with other agencies to provide consistent, effective, timely care. Supporting people to live healthier lives, access healthcare services and support.

At the inspection in May 2021 the provider had not assessed, monitored and improved the quality and safety of the services provided. This was part of a continued breach of Regulation 17 (Good Governance).

At the inspection in October 2021 we found improvements had been made and the provider was no longer in breach of this part of regulation 17.

At this inspection we found inconsistent record keeping or health records missing or incomplete. This was part of a continued breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At our inspection in May 2021 it had been identified that the provider and previous manager did not work well with professionals visiting the service. At the inspection in October 2021 we found professional relationships had improved. Professionals were still working closely with the management of the service. However, inconsistencies in senior management and management of the service had been challenging.
● People's health conditions were not always documented clearly or consistently. For example, one person had multiple health conditions. However, these were not recorded clearly for staff. In particular agency staff who did not work at the home and were not familiar with the service's care records. Another person who was at high risk of falls did not have a risk assessment in place. This meant staff did not have the information they needed to ensure care delivery was effective.
● A person's record included the need for staff to always have 'line of sight observations' due to their behaviour. However, this was not always carried out. A member of the inspection team needed to intervene and call for assistance for one person due to the lack of staff available.

The provider had not assessed, monitored and improved the quality and safety of the services provided. This was part of a continued breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● People's individual needs had not always been assessed before they moved into the service. Records

showed a new admission to the service did not have a pre-admission assessment completed. This meant staff did not always have the information they needed to effectively respond to the person's needs.
●Peoples choices had been recorded. For example, one person had recorded they would prefer male staff or mature staff to attend to their personal care needs. However, records showed many occasions when young female staff had assisted this person. This had led to the person concerned becoming distressed and then challenging and staff being injured. Following our inspection we received information that this person had sustained an injury with cause recorded as 'unknown'. However, this is currently being investigated by senior management and the local safeguarding team.
●Care plans were developed for people's individual needs and staff had guidance on how to meet those needs. However, due to staff shortages these needs where not always met. For example, the person who preferred to be supported by male or mature staff, a person who was at high risk of falls and needed to be monitored every 15 minutes, and another person who required to have 'line of sight observations' at all times.

The provider had not ensured people's preferences of their care, the appropriate needs of people was met or carried out an assessment of needs. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet

● Hot and cold drinks were served regularly throughout the day to prevent dehydration. However, we observed one person, who wished to remain in their bedroom, who had been supplied with a drink, not being supported appropriately. Staff re-visited this person after 15 mins and removed the drink without checking why they had not drunk it.
● People were provided with healthy meals. Staff were aware of any specific dietary requirements. For example, if people needed their food to be pureed to minimise the risk of choking.
● Nutrition and hydration care plans were in place and covered people's dietary needs. They were detailed about what assistance from staff was needed. When people's food and fluid intake needed to be monitored, we found records were consistently completed and acted upon if necessary.

Ensuring consent to care and treatment in line with law and guidance

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

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

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

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

At our inspection in May 2021 we found that the provider had not ensured that all staff received appropriate training as is necessary to enable them to carry out the duties they are employed to perform. This was a breach of regulation 18 (Staffing).

At our inspection in October 2021 we found that some improvements had been made. However, not all training had yet been completed. Therefore, the provider remained in breach of Regulation 18 (staffing).

At this inspection we found some staff had still not completed appropriate training as necessary to carry out their duties. Not enough improvement had been made at this inspection and there was a repeated breach of regulation 18 18 (Staffing) of the HSCA and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We found that 36% of staff have yet to complete training on the MCA. Not all staff had been given the knowledge and skills to comply with the MCA and DoLS.

The provider had not ensured all staff received appropriate support, training, professional development, supervision and appraisal, as is necessary to enable them to carry out the duties they are employed to perform. This is a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Capacity assessments were not always completed to assess if people were able to make specific decisions. For example, we found no appropriate agreement under the Mental Capacity Act 2005 had been put in place, to permit delivery of care by force against one person's wishes. Therefore, the care plan did not provide staff with guidance on how to give personal care when consent had not been obtained.

The provider had failed to ensure the care and treatment provided to people must be with their consent. This was a breach of regulation 11 (Need for Consent) of the HSCA and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●We received information from a professional before the inspection to say one DoLS authorisation had now lapsed. They went on to say they had contacted the service management about this issue with no response, due to that manager having left the service. However, during the inspection an assessor from the MCA/DoLS authorisation team attended the service to complete this assessment.
● For other people who lacked mental capacity, appropriate applications had been made to obtain DoLS authorisations, when restrictions or the monitoring of people's movements were in place.
● Records were held showing which people, living at the service, had appointed Lasting Powers of Attorney (LPA's). This was clearly recorded in people's care plans. Families were encouraged to be involved in people's care plan reviews.

Requires Improvement

Is the service caring?

Our findings

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

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

● The high needs of people, high use of agency staff, and the low number of staff on shift impacted on how people were treated. Staff did not always have the time to spend time with people, to listen to them and support them. We observed people sat in the lounge area with little or no interaction for long periods of time. For example, a person who required staff to have 'line of sight' at all times had to have intervention from the inspection team to find a member of staff to assist them.
● Staff were not all provided with training in diversity and equality to ensure they respected people's individual needs. Currently 52% of staff had completed this training.
● Staff informed us that one person who was meant to have observations every 15 minutes had not had these observations although three hours had passed.

The provider had failed to ensure sufficient employed staff were available to provide consistent care. This is a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● When staff had the time, they supported people with sensitivity and compassion and were quick to respond to people's emotional needs. Throughout the inspection we saw many examples of staff responding to people and acts of kindness were seen with staff talking with people to provide reassurance.
● Staff said they supported each other and said this had been particularly important during the constant changes of managers and during the COVID-19 outbreak in the service. Staff talked about the sadness of the number of people who had passed away and the impact it had on them.

Respecting and promoting people's privacy, dignity and independence

● People were not always supported in a way that promoted their dignity and independence. For example, we were informed by staff that, even though a person declined personal care, four staff members still carried this out by 'holding them (the person) down'.
● People's rights to privacy and confidentiality were not always respected. A relative informed us after the inspection that they heard information about their relative from people in the local community.

At the time of our inspection we found no evidence that people had been harmed however, systems in place were not robust enough to ensure people's privacy and dignity was respected. This was a breach of

regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's privacy was respected. When providing personal care to people in their rooms staff ensured doors and curtains were closed.
● People were supported to maintain and develop relationships with those close to them. Due to COVID-19 restrictions additional support was put in place to enable people to see relatives safely.
● We observed some interactions where regular staff promoted people's dignity and independence and showed compassion towards people who lived at the home.

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

● Care records held information and instructions for staff on how to help people with their personal care. However, one person had requested male staff or more mature staff to assist with their personal care. Records showed this request had not been followed.
● We observed staff asking people for their input when delivering care and when assisting with food or drink in the lounge area.
● People's rooms were decorated and furnished to meet their personal tastes and preferences.

Requires Improvement

Is the service responsive?

Our findings

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

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

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

● People's care plans held information that was important to them. However, we found that one person's care was not delivered in line with their preferences. Their care plan detailed they liked to either have male carers in attendance or more mature staff when personal care was carried out. We found several records of incidents where four young female staff attended to their personal care needs against their wishes. This caused this person distress and agitation. This issue was raised with the new manager and area manager on the day of inspection. However, both the new manager and area manager had left the service by the end of that week. We were therefore unable to confirm what action had been taken.
●Staff were mostly responsive to people's needs and requests for assistance. However, during our observations the inspection team had to intervene when people required assistance. This was due to no staff present as required for people.
●Care plans did not always hold essential information to provide the staff team or agency staff with detailed instruction about people's personal preferences, care needs and medical history. For example, someone who was high risk of falls did not have a falls risk assessment in place.
● Staff had a knowledge of people's personal histories, their likes and dislikes and how they wished to be supported. This information was used to support people. However, when preferences were recorded these were not always followed.
●People's care plans were not always reviewed or updated when people's needs, or abilities changed.

The provider had failed to ensure the care and treatment provided to people must be with their consent. This was a breach of regulation 11 (Need for consent) of the HSCA and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 we recommended the provider review guidance to ensure the provision of activities met people's needs and preferences.

At this inspection we found some improvements had been made. However, some staff raised concerns over the quality of the activities offered to people. Therefore, the recommendation remains in place.

● There was an activities co-ordinator working in the service. However, they were not on duty on the day of

our inspection. We observed minimal activities taking place. The service had a separate activities room however this was not being utilised to support people to follow their interests. Staff continued to say that due to staffing levels they did not always have time to carry out activities.
●People were supported to maintain relationships which were important to them, with friends and relatives particularly during the ongoing COVID-19 situation.
●Due to the health needs of some people they spent their time in their room or in bed. Staff checked on people's welfare and held conversations with them. However, we saw it was over 30 minutes between each interaction and we observed these interventions were very brief. This person was also observed calling for assistance and there were no staff within that area. A member of the inspection team called for assistance for this person. Staff said it varied day to day based on staffing levels, about how much time they could spend with people.

Improving care quality in response to complaints or concerns

At the inspection in May 2021 the provider had not assessed, monitored and improved the quality and safety of the services provided. This was part of a continued breach of Regulation 17.

At the inspection in October 2021 we found improvements and the provider was no longer in breach of this part of regulation 17. No further complaints had been received.

● The provider had a complaints procedure available. There were no ongoing complaints at the time of the inspection.
● No quality assurance surveys had been undertaken since the last inspection. People were not able to say if they felt their complaints would be acted on.

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.

●People's care records outlined any communication needs and documents could be provided in other formats if required.
● During the COVID-19 outbreak in the service, staff had assisted people to remain in contact with family and friends. This included through using electronic devices. This system remained in place.

End of life care and support

● The impact of the COVID-19 outbreak meant staff had cared for many people at the end of their lives during an earlier outbreak at the service. All care plans had clear end of life plans in place for staff to follow people's wishes.
● Staff had experience of caring for people at the end of their lives. The number of staff who had completed end of life training has increased.
● People were supported to make decisions and plans about their preferences for end of life care.

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 inspection in May 2021 this key question was rated inadequate.

At the inspection in October 2021 the service had improved to requires improvement.

At this inspection the service had deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements.

At our inspections in November 2019, July 2020, November 2020, February 2021, May 2021 and October 2021 the provider had failed to establish satisfactory governance arrangements and to maintain an effective overview of the home or taken sufficient action to make the required improvements identified in the previous inspections.

This was a repeated breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service is required to have a manager registered and registered individual with the Care Quality Commission. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. At the time of this inspection the service had not had a registered manager since the beginning of June 2020. At the last inspection there was the operations manager overseeing the service. This was due to the previous managers leaving without completing the registration process. This operations manager left soon after the last inspection in October 2021. At this inspection a new manager was on their first day and was being supported by the area manager. However, shortly after the site inspection both the manager and the area manager had left the service. This meant the service had no manager in post and no senior manager overseeing the operation of the service. Following the inspection we were informed a senior manager had been appointed; however, they were not due to commence until the following week. There was clear evidence of consistent poor management retention, which was affecting all aspects of the operations of the service and resulting in poor outcomes for people and staff.
● There had been a lack of consistent management of the service since a long-standing manager left in December 2019. There had been seven managers for short periods since then. Though we found some improvements had been made in our October inspection with systems and processes, since then there had been no stable management and these had not been maintained. Systems and processes continued to be changed and not effectively implemented or embedded.
● The clinical lead post also remained vacant. This vacancy had been noted in our inspections of May 2021,

October 2021 and this inspection.

● Inconsistent management had resulted in the lack of assessment and monitoring of the safety and quality of the service. For example, we received an action plan in May 2021 highlighting areas within the home that needed upgrading. One such area was the grounds and garden. The report stated; "Outdoor grounds and areas to be improved for the benefit of residents." On this inspection we found areas outside strewn with rubbish and broken items.

● At our previous inspections we found audits were not always fully effective in identifying areas for improvement. At this inspection we found some audits had not identified areas for improvements, or where they had, actions had not always been taken to make the changes. This meant some improvements had not being actioned to ensure a safe and effective service. For example, medicine audits had not identified when one person, who had been assessed as needing 'as required' medicines, had not received these medicines in a way which would have improved their wellbeing and quality of life and reduced the likelihood of physical restraint.

● At our last inspection we found some gaps in records although some auditing systems had improved. However, since the departure of the most recent operations manager, there were gaps in the documentation. For example, falls audits did not highlight that one person who was at high risk of falls did not have an assessment in place.

●Staff recorded where people displayed behaviours that challenge on daily records. These were not always reviewed as an accident or incident. Therefore, we were not assured management were reviewing all incidents and identifying themes or learning to mitigate the risk of them happening again.

● Accident forms had been completed for both people and for staff who had been injured. As it was the first day for the new manager the area manager was asked about these serious injuries. The area manager confirmed they had not been informed about these incidences and no follow up or management oversight had taken place to protect both staff and people.

●We found care plan audits were ineffective in identifying gaps in information for staff to support people who displayed behaviours that challenge. During this inspection we found where people's triggers were clearly recorded, these where not being followed and there was no evidence of positive behaviour plans in place. This meant people were at risk of harm or unsafe care.

●The provider had a system in place to review people's care plans. These reviews however, had not identified what we found, where people's needs had changed, and information required updating.

The provider's governance systems remained ineffective in improving the service people received. This was a continued breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, systems were either not in place or robust enough to identify issues and make improvements and there was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection there was still a breach of regulation. The provider has been in breach of this regulation for the last six consecutive inspections.

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 inspections, May 2021 and October 2021, the provider had not assessed, monitored or improved the quality and safety of the services provided. This was part of a continued breach of continued 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 remains in breach of this part

of regulation 17 (Good Governance).

● At the last inspection the manager at the time had been reminded that no notifications had been sent to CQC in line with the regulations. This had since been actioned and completed notifications were now sent as required. However, back dated notifications recording the number of deaths due to COVID-19 outbreak were never received.

The provider's governance systems remained ineffective in improving the service people received. This was a continued breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care

At the last three inspections and this inspection, we found the provider had not ensured staff received appropriate support, training, supervision and appraisal. This is essential in enabling staff to carry out the duties. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and there was a repeated breach of regulation 18 (Staffing). Staff training still needs to be completed.

● Managers at previous inspections told us they had set up an on-line training system, to enable all staff to carry out mandatory training. However, at this inspection we found that not all staff had completed sufficient basic training. This has been reported in more detail under the Effective section of this report.

The provider had not ensured all staff received appropriate support, training, professional development, supervision and appraisal, as is necessary to enable them to carry out the duties they are employed to perform. This is a breach of regulation 18 (Staffing) 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

● At our last two inspections surveys of relative's views on the service's performance had not been completed since October 2018, There was limited evidence available to demonstrate people's views on performance of the service had been sought. At this inspection no improvement had been made.
● We found at this inspection 42% of staff needed to complete equality and diversity training to ensure people were protected from all forms of discrimination.

At the time of this inspection we found no evidence that people had been harmed however, the provider had failed to establish satisfactory governance arrangements. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others

At our inspection in May 2021 the provider had failed to assess, monitor and improve the quality and safety of the services provided. At the inspection in October 2021 we found some improvements had been made. However, with the departure of both the newly appointed manager and area manager within a week of our inspection there was no management team on sight or working in the home to support this. The provider

was, however, in contact with the local authority.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured people's preferences for their care, the appropriate needs of people was met or carried out an assessment of needs. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 9 (1. a b c)

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 At the time of our inspection we found no evidence that people had been harmed however, systems in place were not robust enough to ensure people's privacy and dignity was respected. This was a breach of regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 10 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure the care and treatment provided to people must be with

Treatment of disease, disorder or injury	their consent. This was a breach of regulation 11 (Need for consent) of the HSCA and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 11 (1)

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 provider had not assessed the risks to the health and safety of people receiving care. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 12 (2. a) The provider had not ensured the premises used by people are safe to use. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 12 (2. d) The provider had not taken all necessary action to protect people from infection. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 12 (2. h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment

Diagnostic and screening procedures

Treatment of disease, disorder or injury

The provider must ensure the premises used by people is properly maintained.

This was a breach of Regulation 15 (Premises and Equipment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulation 15 (1. e)

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured the proper and safe use of medicines. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 12 (2. g)

The enforcement action we took:

Issue an NOP to issue monthly reports

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure that care and treatment had not been provided in a way that includes acts intended to control or restrain a person that was not necessary. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 13 (4. b)

The enforcement action we took:

Issue an NOP to issue monthly reports

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 had not assessed, monitored and improved the quality and safety of the services provided.

	This was a beach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 17 (2. a) The provider's governance systems were still ineffective in improving the service people received. This was a breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 17 (2. b) The provider had failed to act on previous breaches. This meant the service is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Issue an NOP to issue monthly reports

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 provider had failed to ensure sufficient employed qualified staff were available to provide consistent care. This is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 18 (1) The provider had not ensured all staff received appropriate support, training, professional development, supervision and appraisal, as is necessary to enable them to carry out the duties they are employed to perform. This is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation (2. a)

The enforcement action we took:

Issue an NOP to issue monthly reports