Tudor Care Limited

Beechfields Nursing Home Limited

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

We inspected this service on 7 November 2017. It was an unannounced inspection. Beechfields is a care home that provides accommodation and nursing care. Beechfields is registered to accommodate 35 people. At the time of our inspection 27 people were using the service. Beechfields accommodates people in one adapted building, arranged over two floors. There are two communal lounges, a dining area and a conservatory.

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

At our last unannounced inspection on 15 and 19 June 2017, multiple regulatory breaches were identified. On 5 July 2017 we issued a warning notice to the provider in Regulation 12 HCSA (RA) Regulations 2014 Safe care and treatment. This was in relation to the management of medicines and risks to the health, safety and wellbeing of service users. We told the provider to take action by the 15 August 2017. We also judged the service to be 'Inadequate' and placed into 'Special Measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

This meant the service would be kept under review and inspected again within six months.

When we carried out our last inspection on 15 and 19 June 2017, we found concerns relating to how risks to people were managed. Medicines were not administered and managed safely and staff did not always follow guidance to protect people from avoidable harm. We also found improvements were needed to ensure that staff followed legal requirements to uphold people's rights where they were unable to make certain decisions for themselves and that they followed safe recruitment procedures to ensure persons employed were of good character. We also told them that they needed to ensure that effective systems were in place to monitor the quality and safety of the service and to drive improvement. We issued a warning notice to the provider in Regulation 12 HCSA (Regulated Activities) Regulations 2014, Safe care and treatment. This was in relation to the management of medicines and risks to the health, safety and wellbeing of service users. We told the provider to take action by the 15 August 2017. We rated the service as 'Inadequate' and the provider was placed into special measures. This meant they would be inspected again

within six months with the expectation that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

At this inspection, we found that the provider had made the required improvement in relation to specific concerns identified in the warning notice. However, we have found continued and new breaches of the regulations and have judged that the overall rating for this service is Inadequate. The provider therefore remains in special measures which means we will take action in line with our enforcement procedures to being the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will continue to be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. For adult social care services, the maximum time for being in special measures will usually be no more than 12 months.

Medicines were not always managed effectively to ensure they were always available when people needed them and records were not monitored for accuracy. Potential risks to some people's safety were not consistently assessed and staff did not always have the guidance they needed to ensure people's safety and wellbeing. People were not effectively protected from the risk of abuse. The registered manager had not ensured that safeguarding incidents were recorded and reported to the local safeguarding team where needed.

There were not always enough staff to meet people's needs in a timely way and there was no effective system to monitor staffing levels against people's needs. Improvements had not been made to assure us that safe recruitment procedures were consistently followed to ensure staff were suitable to work in a caring environment. The provider had commenced a programme of training for staff. However, records of staff induction and supervision were not readily available to assure us that the provider had suitable arrangements to support staff to fulfil their role.

People are not supported to have maximum choice and control of their lives and staff do not support them in the least restrictive way possible; the policies and systems in the service do not support this practice

People were involved in planning and reviewing their care but the provider needed to make improvements to ensure people's diverse needs were taken into account in all areas of their care. People's day to day health needs were met but were not always referred to other services to ensure that all their needs were met. People were supported to have sufficient amounts to eat and drink to maintain good health.

People and their relatives felt able to raise concern or complaints. However, there was no effective system in place to record and monitor these for any trends to ensure improvements would be made where needed.

The provider's governance and quality assurance systems were ineffective; they had failed to identify the concerns identified at this inspection or address breaches of regulation highlighted at our last inspection.

People and their relatives were positive about the registered manager and staff and were able to give their views on the service. Although staff were busy, they were caring in their approach and treated people with dignity and respect. They had positive relationships with people and supported them to maintain their independence. People were offered opportunities to take part in activities and follow their interests and their relatives were invited to be involved.

We found a number of continued breaches and a new breach of the regulations. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Some improvements had been made to the management of identified risks. However, potential risks to people's safety and wellbeing were not consistently assessed and managed. Some improvements had been made to the management of medicines but new concerns were found with the management of stocks and accuracy of recording. The registered manager did not follow safe recruitment procedures and there were ineffective systems to ensure there were sufficient staff to meet people's needs in a timely way. The provider did not have effective procedures to assure us that people were consistently protected from the risk of abuse.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The provider had commenced a programme of training for staff. However, records of staff induction and supervision were not readily available to assure us that the provider had suitable arrangements to support staff to fulfil their role. The registered manager and staff were still not meeting the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguard. People's day to day health needs were met but were not always referred to other services to ensure that all their needs were met. People were supported to have sufficient amounts to eat and drink to maintain good health.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff were not always given sufficient time to provide a caring, person-centred service because staffing levels did not support this. However, although staff were busy, they were caring in their approach and treated people with respect. Staff supported people to make day to day choices and promoted their privacy and dignity. People were supported to maintain important relationships.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's preferences were not fully explored to ensure their diverse needs were always met. People felt able to raise any concerns and complaints about their care but systems were not in place to ensure this was monitored for trends to ensure improvements would be made. People joined in social activities they enjoyed.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had not taken action to improve their governance and quality assurance systems; they had failed to identify concerns and effectively address breaches of the regulation. Staff did not always feel their concerns were taken into account by the registered manager and provider

People and their relatives were positive about the staff and registered manager.

Beechfields Nursing Home Limited

Detailed findings

Background to this inspection

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

This inspection took place on 7 November 2017 and was unannounced. The inspection was carried out by two inspectors and a specialist advisor. A specialist advisor is a professional who has expertise in a specific area, our specialist had knowledge as a trained nurse who has experience of working within this type of care service. Following the last inspection, we met with the provider and asked them to complete an action plan to show what they would do and by when. We told them they needed to improve the management of medicines and risks to the health, safety and wellbeing of service users; to ensure that staff followed legal requirements to uphold people's rights where they were unable to make certain decisions for themselves and that they followed safe recruitment procedures to ensure persons employed were of good character. We also told them that they needed to ensure that effective systems were in place to monitor the quality and safety of the service and to drive improvement. The provider wrote to us to tell us what they would do and by when to meet the regulatory requirements.

Beechfields is a care home. People in care homes receive accommodation and 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. Beechfields accommodates 35 people in one adapted building, arranged over two floors. At the time of our inspection 27 people were using the service, some of whom were living with dementia. There are two communal lounges, a dining area and a conservatory.

The inspection was supported by information received from local authority commissioners who told us they had placed an embargo on the provider to prevent admissions as they had ongoing concerns about the

quality of care being provided and were working with the provider in relation to these to bring about improvements. The local authority safeguarding team had notified us of an ongoing safeguarding investigation at the service, which raised concerns about safe care and treatment for a person living at the service. We reviewed other information we held about the service in relation to statutory notifications the registered manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law.

We also used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used all of this information to help us plan the inspection visit.

We spoke with three people, six relatives, four care staff, two nurses (one of whom was the deputy manager), the cook, and the registered manager. We did this to gain views about the care and to ensure that the required standards were being met. 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 looked at the care records for seven people to see if they accurately reflected the way people were cared for. We also looked at staff duty rosters, four staff recruitment files, ten medicine administration records and the provider's health and safety checks.

Following the inspection we asked the provider to send us information in relation to the induction , appraisal and supervision processes, staff meeting minutes and action plans in relation to the provider's fire risk assessment and infection control audit. We requested the information by 13 November 2017. We have not received information in relation to the induction process.

Inadequate

Is the service safe?

Our findings

At our last inspection, we found that risks associated with people's care were not always managed in a safe way. People's medicines were not administered, stored and recorded safely. Staff did not always follow care plans to minimise identified risks and when people's needs changed, good practice guidance was not always followed. This was a breach of Regulation 12 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014. We issued the provider with a warning notice to improve the management of risks associated with people's medicines and care. We told the provider that improvements must be in place by 15 August 2017. At this inspection, we found that some improvements had been made but further improvements were needed.

Medicines stocks were not always well managed and we saw that some people's medicines had occasionally run out. For example, one person's medicine to help them sleep had been out of stock for two days because an insufficient amount had been dispensed at the start of the cycle and the staff had failed to follow this up in time. The member of staff administering medicines told us the person had not needed the medicine during this time and thought the shortfall had been followed up with the person's GP. Another person was administered paracetamol by an agency night nurse but their medicine administration record (MAR) showed that that there was no stock available for most of the cycle. The member of staff could not give an explanation for this. They told us medicines were usually delivered only a few days before the new cycle commenced, which gave them little time to address errors in time. They told us they were not given additional time to book in medicines and the night nurse checked all medicines in whilst being the only nurse on shift. Discussions with the registered manager showed that they were not aware of these issues and there was no evidence that staff had contacted the GP to seek guidance when omissions occurred. This meant we could not be sure that safe systems were in place and people received their medicines as prescribed.

Potential risks to people's safety and wellbeing had not been assessed consistently and staff had not been given detailed guidance to reduce and mitigate risks. We saw that some people presented with behaviours that required support from staff. For example, on the day of our inspection a person became agitated and staff tried without success to settle them. There was no clear guidance to direct staff on how they should respond to the behaviours and what action they should take to support the person. This meant there was a risk that the person would not receive consistent support that ensured their safety and wellbeing.

We found the provider did not have suitable arrangements in place to ensure accidents and incidents were recorded and investigated thoroughly. We discussed an incident that had been referred to the local authority safeguarding team by a visiting health professional. They had observed that a person was at risk of receiving unsafe care because staff were not supporting them in accordance with their assessed needs. We saw that the incident had not been recorded internally and the registered manager had not carried out an appropriate internal investigation to make sure that action had been taken to prevent further occurrences. This showed us that when concerns were raised on things that go wrong, the provider's approach to reviewing and investigating these causes was not always effective.

This evidence shows there was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People were not always protected from the risk of abuse. Staff had not received safeguarding training and did not know the procedures for reporting concerns to the local safeguarding team. The provider's action plan stated that there should be a safeguarding file with information on how to report and log any concerns. This was not in place. We found that there had been instances where a person had left the home without the knowledge of staff and were at risk of injuring themselves. Whilst the person had not come to any harm, there were no records of these incidents and no evidence that the registered manager had sought the advice of the local safeguarding team. In addition, missed medicines referred to above had not been identified as potential safeguarding incidents. This showed us the provider had not implemented procedures and processes to ensure people were protected from the risk of abuse.

At our last inspection, we had identified a breach in the recruitment checks for staff. At this inspection, the required improvements had not been made and we could not be assured that people were protected against the risk of being cared for by unsuitable staff checks. We checked files for new members of staff that had started at the service and found that the registered manager had allowed staff to start work without all the relevant checks having been completed. For example, there were no records for one member of staff, who told us they were still completing their application form and had not yet provided references for the registered manager to follow up. Two other members of staff had gaps in their employment history but there were no interview notes to show that these issues had been followed up by the registered manager. We also found that the registered manager had not assured themselves that agency nurses had an up to date registration with the Nursing and Midwifery Council. We asked to see a copy of the profile provided by the agency which would contain the nurse's registration number. However, the registered manager was unable to produce it and had to contact the agency to obtain it.

This meant there was a continued breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People and their relatives told us there were not always enough staff to provide timely support. One person said, "I'm very independent but sometimes I have to wait a long time for staff to help me to go to the toilet". A relative said, "Sometimes they are short of staff". We saw that at times people waited for up to 15 minutes when they asked staff to assist them and call bells frequently rang for more than ten minutes before being answered. On one occasion, we observed there was one member of staff supporting people in the communal lounge and they had to ask two people to wait whilst they supported another person. Staff told us there were not enough staff to meet people's needs, especially in the morning when there were a number of people who required the support of two staff. One member of staff said, "We feel really pushed and can't deliver the care we want to. We have five care staff today but we really need six". Another said, "We have a high number of people who need the support of two care staff and this means people sometimes have to wait". At the last inspection, we asked the provider to review staffing levels against people's individual needs to ensure there were sufficient staff at all times. The registered manager could not evidence that they had carried out any review of people's dependency levels and told us the current staffing levels were determined by the provider due to the low occupancy at the home. They told us they did not have sufficient employed staff available to roster six care staff and existing staff were already working overtime to cover vacancies. This showed us the registered manager did not have a systematic approach to determine the number of staff needed to meet people's needs and keep them safe at all times.

This is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The provider was working towards meeting current national guidance and standards in relation to infection control. An audit had been carried out in July 2017 by the health and social care partnership trust and the provider forwarded us their action plan following the inspection. This did not clearly identify progress and our observations at the inspection showed that a number of actions had not been completed. For example, a suction machine was identified to be dusty. At the inspection, we saw that it was still dusty and the tubing was clogged with debris and lying on the floor of the person's room. We brought this to the attention of the registered manager.

We saw that improvements had been made to the décor at the home to address infection control concerns, and that it was clean and odour free. Staff understood their responsibilities for maintaining high standards of cleanliness and hygiene at the home and were due to undertake training at the end of November. The registered manager had ensured that concerns identified during a recent food hygiene rating check had been addressed and a follow up visit by the local authority environmental health team was awaited. We will check this at our next inspection.

Other concerns about medicines management from the last inspection had improved. We saw staff followed good practice when administering people's medicines. Medicines with a short expiry were dated when they were opened. This meant that staff could ensure that the medicines had not passed their expiry date and were still effective. Medicines were also stored safely within the recommended temperature ranges; this included medicines which should be stored in a refrigerator.

Other risks were assessed and managed and staff were given guidance on how to support people safely. Discussions with staff showed they understood how to minimise risks associated with people's mobility and we observed staff moved people safely using equipment and supported. Staff told us how they protected people's skin from harm; they knew how often people needed to move their position and what equipment they required. Staff were also able to tell us how they assisted some people with their food and drinks to avoid the risk of choking.

Requires Improvement

Is the service effective?

Our findings

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. The authorisation procedures for this in care homes and hospitals are 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 were being met.

At our inspection in June 2017, the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014 because staff did not always follow the principles of the MCA and DoLS. Decisions were being made in people's best interest without carrying out a mental capacity assessment to determine if they could make the decision for themselves. At this inspection, we saw that mental capacity assessments had been carried out where the staff believed the person may not have the capacity make decisions for themselves. However, these were not decision specific and staff had made certain decisions in people's best interest, for example to have the flu vaccination. We saw there were no assessments to determine if these people could make the decision for themselves and some relatives had given their consent for the vaccination but there was no evidence to show they had the legal authorisation to do this. For example, there was no copy of a Power of Attorney authorisation. This meant the provider was still not meeting the requirements of the Act to ensure people's rights were upheld.

At the last inspection, we found staff knowledge of MCA and DoLS was inconsistent and the registered manager lacked knowledge of how to apply the legislation. In particular where people were unable to leave the service without the supervision of staff because the doors were locked. At this inspection, we found the provider had failed to properly train and prepare their staff in understanding the MCA in general and the specific requirements of the DoLS. For example, we saw that a person was taken to their bedroom when they became unsettled and kept trying to get up from their chair. Staff told us this was because the person was at risk of falls. The registered manager did not recognise that taking the person to their bedroom amounted to a restriction and had not applied for a DoLS authorisation. In addition, where people were living with dementia, the registered manager did not recognise the need to consider their capacity in relation to the DoLS. This showed us the registered manager still lacked the understanding of how to apply the MCA and DoLS to ensure staff acted in people's best interest.

This was a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Although we found that staff lacked understanding of the legal requirements, our observations showed that staff understood the importance of gaining people's verbal consent. We saw that staff explained to people what they were doing and waited for people to give their consent before providing care and support. They told us how they supported people to make day to day decisions as far as they were able, for example by showing people choices of clothing or different meals or drink options.

At the last inspection, the provider had not ensured that staff received effective training and support to fulfil their role. This was a breach of Regulation 18 (b) of the Health and Social Care Act 2008 (Regulated Activities) 2014. At this inspection, we found that staff training was still not up to date and our observations showed that some staff lacked the skills and knowledge to effectively support people living with dementia. When people became agitated and repeated requests to go home, although staff responded in a kind and caring manner they did not try to orientate the person to their current environment. This showed us staff were not always supported to provide effective care in line with best practice. The registered manager told us that training had been delayed. On the day of our inspection, staff were undertaking training in safe moving and handling at the home, provided by an accredited training provider. The registered manager showed us training was planned for the next two months, which included topics relevant to people's needs, including dementia awareness. We saw the registered manager had introduced a system to monitor the training to ensure staff knowledge was kept up to date.

Staff who had recently started working at the service told us they had received an induction and were working through a booklet, which needed to be signed off by the registered manager. We asked the registered manager to provide evidence of this following the inspection, but to date this has not been received. They told us that any staff who were new to care would be enrolled on the Care Certificate; a nationally recognised qualification which supports staff to gain the skills and knowledge needed to work in health and social care setting. The registered manager told us that no staff had completed it so far as they usually recruited staff that had competed other qualifications in care. We saw that the registered manager had begun to carry out supervision and appraisals for all staff, which gave them an opportunity to discuss their performance and identify any training or development needs. Whilst this showed us the provider was working towards ensuring all staff received effective training and support, there was no system to schedule meetings and monitor progress. We will follow this up at our next inspection to ensure the provider has a consistent approach to supporting staff to meet people's needs effectively.

People were offered a choice of meals and had access to sufficient food and drink throughout the day. People's feedback was sought and menus were planned around their preferences, for example a vegetarian option was available. Discussions with the chef showed they understood the need to provide meals that met people's individual needs. However, records we looked at did not show that people's cultural needs or religious preferences were explored. This was an area for improvement. The chef was aware of people's specific dietary needs, for example where people needed a soft diet to minimise the risk of choking, and we saw that these were followed. When people's relatives brought in treats for their family members, the chef checked these were appropriate in relation to people's dietary needs and ensured the person was served them. At mealtimes, we saw that staff were available to support people and encouraged people to eat and drink sufficient to maintain good health.

People's needs were assessed by the registered manager prior to moving into the home and the information was developed into a care plan. However, we found that people were not always referred to external services to make sure all their needs were met. As noted in safe, a person who was living with dementia had got out of the home on a number of occasions. Discussions with their relative showed the person may be 'sundowning', a symptom whereby their confusion and agitation becomes worse in the late afternoon and evening. However, there was no evidence to show that this had been recognised by the nursing staff and no

referral had been made to community mental health services to ensure their needs were met. This meant the staff had not taken action to ensure the person's care and support achieved outcomes that promoted their wellbeing. The topic areas relating to this concern were under the key question of Responsive in the previous assessment framework, but were moved to this key question when the framework was reviewed and refined.

We did see other examples where people were supported to access other professionals to maintain their day to day health needs. For example, we observed that a person was supported to attend a GP appointment. Staff recorded visits from other health professionals, including dietician, occupational therapist and optician to ensure their advice was acted on.

The provider had involved people in decisions about the improvements being carried out to the home environment. The registered manager told us that one person preferred not to have their bedroom decorated and their wishes were respected. Whilst the registered manager told us that further improvements were planned at the home, there was no plan in place to demonstrate this. We observed that improvements were needed to the garden areas, which were uneven in places and not easily accessible for people.

Requires Improvement

Is the service caring?

Our findings

At the last inspection we asked the provider to make improvements because people did not always feel staff listened to them and their dignity was not always promoted. At this inspection, people and their relatives were positive about the staff and told us they looked after them well. A relative told us, "The staff are amazing with [Name of person], they do a great job". Another said, "I'm extremely satisfied with the way staff care for [Name of person]. A third said, "Staff are very kind". However, people and their relatives told us the staff were busy and were not always able to spend time with them on a one to one basis. They told us there was a high turnover of staff which meant there were constant changes. One person said, "There are a lot of changes with staff, they come and go". Staff we spoke with told us they understood that things needed to improve at the service, particularly the need to record things accurately. They told us they felt under pressure to complete personal care tasks and paperwork and this sometimes compromised the quality of care people received. One staff member told us, "We need more staff so that we can make the improvements needed. We feel really pushed and can't deliver the care we want to. We are trying so hard to move forward and want to improve; we don't want to be inadequate again, it doesn't reflect what we do". This showed us the provider did not always ensure staff had the time they need to provide care and support in a caring and person-centred way.

We saw examples of positive interactions between people, their relatives and the staff. Staff treated them with kindness and respect and people looked at ease with staff. Staff listened to people and showed concern for their wellbeing. For example, we saw staff chatted briefly with people when supporting them to their preferred armchair and checked they were comfortable before leaving them. This showed us staff cared about people's wellbeing.

We saw that people were treated with dignity and respect. Staff knocked on people's bedroom doors and spoke discreetly to people when responding to their requests for support to go to the bathroom. Staff told us they always made sure people's doors and curtains were closed when supporting them with personal care. One member of staff told us, "I always make sure I cover people when I'm helping people with personal care to maintain their dignity".

People were supported to make choices about how they spent their time. We heard staff asking people where they would like to sit and their preferences were respected. We saw that some people moved freely about the home and went up to their bedrooms when they wanted some quiet time. People were encouraged to maintain their independence. One member of staff told us how they supported a person who found it difficult to brush their teeth, "I help to guide them, rather than taking over". Staff treated people as individuals and understood their communication needs. For example, one member of staff told us how they supported a person who had a hearing impairment who used a whiteboard. They told us, "I use the board to introduce myself and ask them things, for example if they would like their breakfast".

People were able to see their family and friends without restriction; at lunchtime we saw a relative had a meal with their family member. They told us, "I come here every day and I'm able to have a meal with

[Name of person]". Relatives told us they felt welcomed when visiting and were kept informed about their family member.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection, we asked the provider to make improvements to ensure care planning focussed on meeting people's individual needs and preferences. At this inspection, we saw that people's religious beliefs were considered and people received Holy Communion, which was attended by a number of people and their relatives. Discussions with staff showed that they recognised that people's values and beliefs influenced their decisions on how they wanted to receive their care and support. However, we did not see that this was fully considered in the assessment and care planning process to ensure people's diverse needs were recorded. For example, people's faiths and cultures were not explored in end of life planning. This meant we could not be sure that needs relating to people's protected equality characteristics would be met. The registered manager told us they were in the process of updating the care plans and all policies and procedures, including Equality and Diversity. We will follow this up at our next inspection.

People and their relatives told us they were able to raise any concerns or complaints and found the registered manager listened and responded to them. We saw that a compliments and complaints procedure was on display in the foyer of the home. The registered manager told us this was a new system and no complaints had been received since it had been introduced. We saw that a concern had been raised and the registered manager had met with a person and their family. This meeting had been recorded, however there was no system in place to review and monitor these issues to ensure that any trends would be identified and improvements made where needed. This showed us they had not addressed the concerns we raised at the last inspection.

Relatives told us their family members received care that met their individual needs. One told us, "I just want to say how good the home and staff are. [Name of person] has been ill for a couple of weeks but due to his fighting spirit and really good care, they are recovering well". We saw that people's care was reviewed to ensure it remained relevant and relatives were invited to be involved.

A new activities co-ordinator had recently been appointed within the home and we saw they spent time with people on an individual basis throughout the day. There was a programme of activities on the board, which included pampering sessions, which we observed during our inspection. People told us they were able to choose which activities they joined in with. One person told us, "We have music events but I prefer the quiet and go to my room; I watch TV and look after my plants. We have music and movement; I join in with that". People were supported to maintain important relationships to avoid social isolation. As noted above, people's relatives were invited to join in with activities and were made welcome by the staff.

At the time of this inspection the provider was not supporting people with end of life care, so therefore we have not reported on this.

Inadequate

Is the service well-led?

Our findings

There was a registered manager in post that had been working at the service since 2015. At our inspection in June 2017, we found that breaches of the regulations identified at our inspection in November 2015 had reoccurred. The provider had failed to monitor the service and provide sufficient input to support the registered manager in addressing shortfalls and ensuring past improvements were sustained. The service was rated as Inadequate and placed into Special Measures. At this inspection, we found that the required improvements had not been made and further concerns were identified. This demonstrates a history of non-compliance and lack of action by the provider to make continued improvements to the service.

At our last inspection, we found that a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had reoccurred and the systems used to monitor and improve the service were not effective. Whilst we have seen some improvements in relation to the environment and the commencement of staff training, the provider had not introduced an increased level of monitoring of the service since our last inspection. Visits made by the provider had not been formally recorded and the service improvement plan drawn up by the provider had not been effective in maintaining a focus on areas identified as in the breach of the regulations. We found that areas identified as completed had not been addressed, for example it stated that MCA and best interest decisions were not in place. The plan identified that the registered manager was the person named as responsible for the improvements. However, they told us they had not reviewed the plan with the provider and were not aware of the actions needed. This showed us there was no clear strategy to deliver improvements and no clarity on who was responsible for making the required improvements.

The medicines audits were not effective in ensuring people received their medicines as prescribed. Checks of medicine administration records had failed to identify the concerns we identified with poor practice by the agency nurse and that medicines were not always available for people. We asked the registered manager how they recorded and investigated any medicines errors as the PIR reported that there had been eight errors in the last 12 months. The registered manager told us the PIR had been completed by the provider and could not explain what the errors related to. They also told us they delegated all responsibility for medicines management to the deputy manager. This demonstrated a lack of oversight of the service and meant we could not be sure that appropriate action would be taken to ensure lessons were learnt. In addition, we found gaps on five of the ten MAR charts we looked at, where staff had not signed to say they had administered people's medicines. Although checks of these people's medicine's stocks confirmed that they had received the medicine, staff were not following good practice and monitoring the MAR to ensure people received their medicines as prescribed.

We found that actions in relation to the fire risk assessment seen at the last inspection had still not been completed. For example, portable appliance testing was not up to date and we saw that items such as a television in one of the communal lounges had not been tested since 2013. The provider sent us an action plan following the inspection but this does not identify when all the outstanding issues will be addressed. We also found that some information did not coincide with our findings at the inspection. For example, our

checks identified that fire safety equipment was not always tested, as stated in the action plan. We also found that although some sample tests had been carried out by an external contractor, there were no ongoing checks to minimise the risks associated with legionella bacteria. The registered manager told us this was because they were waiting for the provider to recruit a maintenance officer. This meant we could not be assured that the provider had effective systems in place to ensure the home environment was safe for people.

Insufficient improvements had been made to the oversight of monitoring records. We found that the records were still only kept in the person's room for a two day period before being removed for filing so it was not possible to see at a glance if the person had received sufficient food or fluid. For example, one person's fluid intake was lower than their target amount on two occasions but the records for the third day were not available. The registered manager told us they monitored the records but we saw that three weeks' worth of records for food and fluid intake were stacked in the nurses' room waiting to be looked at. The provider told us that systems had been introduced to ensure people were weighed on a weekly or monthly basis when needed. However, we saw that where there were gaps in the recordings, these had not be identified and addressed by the registered manager. Whilst we had not identified any concerns with the monitoring of people's food and fluid intake and skin integrity, the lack of oversight did not assure us that concerns would be promptly addressed when people's needs changed.

In addition, there were no systems in place to check the accuracy of care plans. The registered manager told us this had not been implemented because new care plans were being introduced. We found some inconsistencies in care plans; one person's dependency score identified that they were independently mobile, but their care plan stated they required the support of one carer. Another person's care plan stated that the person required the support of one carer but we observed two carers supporting the person to transfer. This meant we could not be sure that care plans were up to date and reflected people's current needs.

The provider did not have a suitable system to assess and monitor staffing levels to ensure there were sufficient staff to meet people's needs at all times. The PIR stated that feedback was being sought from staff on the level of care and input required for people. However, although our discussions with staff showed that they had raised concerns about staffing levels and people commented about how busy the staff were at times, there was no evidence that the provider had acted on this.

As noted in safe, insufficient improvements had been made to the monitoring of accidents and incidents. Since the last inspection, nine unwitnessed falls had been recorded but there was no evidence that these had been investigated for the probable cause. Furthermore, although we have identified that people may have left the home unsupervised, there were no records of any incidents or any safeguarding referrals. This meant we could not be sure that action would be taken to reduce the risks of future reoccurrence.

The failure to continually assess, monitor and mitigate the risks to people and improve the quality and safety of the service is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities).

We have identified that the provider and registered manager had not always notified us of incidents and potential safeguarding concerns that occurred in the service. This meant they were not meeting the requirements of their registration with us.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (Part 4).

The provider sought people's views on the service. Relatives we spoke with told us the registered manager was approachable and responded to their concerns. We saw that people and their relatives were invited to give their feedback on the service through a satisfaction survey. Although there were a small number of responses, we saw that these were positive. We also saw that the registered manager had met with people and their relatives on an individual basis if they had any concerns.

We saw that the registered manager had worked closely with the quality lead for the clinical commissioning group. This had supported them to develop their knowledge and address concerns in relation to the prevention and control of infection. This showed us they co-operated with external stakeholders.

We saw that a copy of the last inspection report and ratings poster was on display in the hallway of the home. The provider was aware of the requirement to publish this on their website, which was currently under construction. This is so that people, visitors and those seeking information about the service can be informed of our judgements.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify us of incidents and potential safeguarding concerns that occurred in the service.

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 that people's care and treatment was always provided in a safe way. This included the safe management of people's medicines. Regulation 12(1)(a(b)(g)

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 There were insufficient staff to meet people's needs; the provider did not have a systematic approach to determine the number of staff in order to meet the needs of people using the service and keep them safe at all times. Regulation 18(1)

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 11 HSCA RA Regulations 2014 Need for consent The registered manager and staff were not acting in accordance with the requirements of the Mental Capacity Act 2005 and associated codes of practice. Regulation 11(1)

The enforcement action we took:

We imposed a condition that restricted the provider from accepting any new admissions to the service until the required improvements had been made. The provider is also required to send an monthly report of actions to enable us to monitor the progress of improvements.

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 Effective systems were not in place to continually assess, monitor and improve the quality and safety of the service. The provider did not act on feedback received from people and their relatives, to enable them to evaluate and make improvements in the service. Regulation 17 (1)(2) (a)(b)(c)(d)(e)

The enforcement action we took:

We imposed a condition that restricted the provider from accepting any new admissions to the service until the required improvements had been made. The provider is also required to send an monthly report of actions to enable us to monitor the progress of improvements.

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 provider did not follow safe recruitment procedures to ensure person's employed were of good character.

	Regulation 19 (2)

The enforcement action we took:

We imposed a condition that restricted the provider from accepting any new admissions to the service until the required improvements had been made. The provider is also required to send an monthly report of actions to enable us to monitor the progress of improvements.

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 was not ensuring there was appropriate induction, training and supervision for staff to enable them to carry out their role. Regulation 18 (2)(a)

The enforcement action we took:

We imposed a condition that restricted the provider from accepting any new admissions to the service until the required improvements had been made. The provider is also required to send an monthly report of actions to enable us to monitor the progress of improvements.