Mrs Rose Metcalfe

Beechwood House Rest Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
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
Beechwood House Rest Home is a residential care home providing personal care to nine people aged 65 and over at the time of the inspection. The service can accommodate up to 13 people in one adapted building.

People's experience of using this service and what we found
Quality had deteriorated. The provider had not had close oversight. They had not satisfactorily addressed the issues identified at the last inspection. Their quality assurance had not identified the shortcomings found at this inspection. Records were incomplete and lacked detail. Legal requirements for displaying the inspection rating were not met. We have made a recommendation about understanding the requirement to notify CQC of changes in the management of the service.

People were not protected from avoidable harm. Checks on volunteers and staff were incomplete. There were reports of unkind staff. Incidents were not always reported or addressed. Risk assessments were incomplete or missing. Some environmental risks were not addressed, and there were shortfalls in cleanliness. Medicines were not managed safely.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support least restrictive practice. One person was unduly restricted, and we raised a safeguarding adults referral concerning this.

Staff did not all have the necessary skills to work safely. They did not always seek timely medical advice when people showed signs of being unwell. Assessments and care plans lacked detail regarding people's care needs. Care was often task-focused rather than centred on people's individual needs and wishes.

Most people said they liked the staff and we observed some respectful, gentle interactions. Care was offered discreetly. However, people's preferences were not always respected. People had little involvement in planning their care.

People mostly said they liked the food. However, there was not usually a choice of main meal. People were not always offered alternatives if they did not want what was offered. We have made a recommendation regarding ensuring people always have enough to drink.

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 inadequate (published 22 November 2018); there were multiple breaches of regulation and the service was placed into special measures. The provider completed an action plan after

the last inspection to show what they would do and by when to improve. At this inspection improvements had not been made and the provider was still in breach of regulations.

Why we inspected
This was a planned inspection based on the previous rating.

We carried out an unannounced comprehensive inspection of this service on 28 September, 2 October and 10 October 2018. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment, safeguarding service users from abuse and improper treatment, good governance and notifications.

At this inspection we checked they now met legal requirements.

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

Enforcement
We have identified breaches in relation to safe care and treatment, safeguarding people from abuse and improper treatment, good governance, person-centred care, and the requirement to display ratings.

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 meet the provider to advise them of the proposed regulatory action and to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
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**

Beechwood House Rest Home

Detailed findings

Background to this inspection

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

Inspection team
The inspection was undertaken by an inspector and an assistant inspector.

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

The owner of the service was registered as a manager with the Care Quality Commission. This means they are legally responsible as registered manager and provider for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We spoke with two local authority professionals who work with the service. We used this information to plan our inspection.

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

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

During the inspection
We spoke with seven people who used the service and a visiting relative about their experience of the care provided. We spoke with three care staff and the provider, who was also the registered manager.

We reviewed a range of records. This included five people's care records and eight people's current medicines administration records. We looked at two staff files in relation to recruitment, training and supervision. We also checked a variety of records relating to the management of the service.

After the inspection
We received some information from the provider that was promised during the inspection, including details of what they were doing to address the issues found. We prompted the provider to send other information that had been requested, such as training records and certification for the inspection of the bath hoist. Some of this was received after the agreed date, including current certification for the inspection of the bath hoist. Other information remains outstanding, including the training records.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong; Recruitment

At our last inspection the provider had failed to protect people from abuse and improper treatment. Systems and processes did not operate effectively to prevent abuse, nor to investigate immediately any allegations or evidence of abuse. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found improvements had not been made and the provider was still in breach of regulation 13.

● Staff recorded adverse events in an accident book and the provider analysed these monthly to identify any trends. However, not all incidents had been recorded and followed up, making safeguarding adults referrals as necessary. This included an episode of poor moving and handling reported during staff supervision. We made safeguarding referrals ourselves during the inspection.
● Three individuals told us about a member of staff being unkind. There was no risk assessment on their staff file to address a concern flagged at recruitment, and their employment history was incomplete.
● A person told us they thought staff disliked them: "They said I was rude this morning. I know I was, but [another member of staff] was rude to me first." Staff were completing a behaviour chart, although the person's care plan gave no indication this was necessary, and daily notes described the person being "rude" and "not helpful". Some staff had treated the person unfavourably because of this, for example, delaying bringing drinks and snacks.
● The service had two volunteers who ran some group activities. The provider had not obtained DBS clearance or references to assure themselves they were suitable to work in a care setting. We also received feedback that a person without DBS clearance or references had recently been working unsupervised in the service.
● The provider described how they had been uncertain about local safeguarding adults procedures. They said, "I don't know what to raise to safeguarding… I didn't know the in depth, that you can report anything."

People were not protected from abuse. Systems and processes were not operated effectively to prevent abuse, or to take appropriate action when there were allegations or evidence of abuse. This was a continued breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded following the inspection. They advised that a recruitment risk assessment had been

reinstated to the staff file for the employee for whom risk factors had been identified, but did not state where it had been.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to assess robustly, and to do all they could to manage, risks relating to people's health, safety and welfare. They had also failed to ensure the premises and equipment were safe and used in a safe way. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found improvements had not been made and the provider was still in breach of regulation 12.

● People's risks were not always assessed, and risk assessments were not all readily available. There was no risk assessment for a person's bed rails, which can be hazardous if used incorrectly, nor for someone's reclining chair, from which they had fallen previously. The provider said someone had been racist towards staff but had not risk assessed this.
● Some risk assessments were inaccurate or incomplete. At handover staff said they had used a slide sheet when providing personal care, but there was no mention of slide sheets in the person's moving and handling assessment or care plan.
● A person's Waterlow score for pressure ulcer risk was nil. This is not possible as they would score points for age and gender. The scale used did not consider this, nor did it score for risks such as neurological issues. This could lead to underestimated risks and insufficient preventative action.
● Environmental risks had not all been identified, or action taken to address them. Radiators were not covered. Wardrobes were not secured to the wall or risk assessed. Bed brakes were not on, which meant beds could move if someone went to sit on them.
● Hazardous substances were not all stored safely. We found denture cleaning tablets and a container of urine neutraliser in people's rooms. Cleaning chemicals including bleach were stored in unlocked containers in the back garden, which was accessible to people although they did not use it.
● The premises and equipment were not managed safely. The gas safe certificate was more than 12 months old. There were no routine precautions against legionella (bacteria that can cause serious illness). There were shortcomings in fire precautions. There was no current certification for the safety of the bath lift.

We found no evidence that people had been harmed. However, systems were either not in place or not robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider addressed some of these issues during and after the inspection. They took the denture cleaning tablets and urine neutraliser for safe storage when we highlighted this. A gas engineer inspected the gas appliances during the inspection and provided a current gas safe certificate. The provider informed us they had requested a water hygiene company for an urgent legionella risk assessment. They said they would commence water temperature checks and flushing infrequently used outlets. They advised that wardrobes were being secured following the inspection. They noted that risk assessments had been archived when they should not have been, and that those that were in place were difficult to understand. They advised these had been placed on files and would be updated as they worked through each person's care plan. For example, a new risk assessment for the use of bed rails was written where this had been missing from the person's file. They forwarded a certificate for the examination of the bath lift, which was

dated following the inspection and stated the lift had not been checked since 2012. They maintained that the last check had been in 2018 and advised us they had requested the contractor to clarify this.

Using medicines safely

● Medicines were not managed safely.

● Five people's medicines administration records (MAR) lacked details of their allergies to medicines. One of those people had a hospital discharge summary from 2018 that mentioned allergies and sensitivities to several medicines. This put people at risk of taking medicines they were allergic to, which could cause serious harm.

● Some people were prescribed medicines to be taken PRN (as necessary). Twelve PRN medicines did not have a corresponding plan with instructions for staff about safe usage.

● Handwritten amendments to MAR were not countersigned as a check they were correct. This presented a risk that people would not have their medicines as prescribed if staff were following incorrect instructions.

● Staff did not write the date of opening on the containers of prescribed creams. This presented a risk creams could be used after their expiry date.

We found no evidence that people had been harmed. However, medicines were not managed properly and safely. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider addressed some of these issues during and after the inspection. They informed us they had rectified the missing allergy details on MAR and that PRN instructions had been completed.

Preventing and controlling infection

● A person living at the service and a visitor said they thought the home could be cleaner. Most areas were visibly clean, but there was dust and dirt in places. For example, there was a dead fly on the bathroom windowsill on both days of the inspection.

● There was a crack in the surface of the bathtub and layers of the bath panel were peeling away. This made it difficult to clean the area effectively. There was also a risk of people catching their legs on the bath panel.

● A communal bathroom jug contained remnants of an unknown substance, which should have been cleaned away. There was a basket of toiletries including disposable razors in the bathroom, not labelled with people's names. Sharing toiletries and this type of equipment presents an infection control risk.

● Personal protective equipment such as gloves and aprons were available around the building for staff. Hand sanitiser was also available around the building, as hand washing facilities were not available in every area. Staff knew when they should use these precautions and we observed them doing so.

Staffing

● There were enough staff on duty to provide for people's care needs. A member of staff commented, "We do not have people here with high needs at the moment, so we have time to give to people".

● However, a person said they sometimes had to wait for assistance if staff were busy. Another person commented, "Personally I don't think there's enough staff. I do like fish and chips but today we've had to have fish and chips again as there is no chef again." The chef was unexpectedly off work on one day of the inspection.

Inadequate

Is the service effective?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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.

At our last inspection we recommended the provider sought appropriate advice and guidance to ensure that the MCA and its processes are embedded. The provider had not made improvements.

- The provider and some staff prevented a person who was able to operate their reclining chair from having the controls as they had fallen from it previously. This unduly restricted the person, who otherwise had difficulty moving themselves and had to remain in the position staff placed them in.
- Staff had acted against the person's wish to be able to adjust their own position, by deliberately leaving the control panel out of reach. This was despite the person having capacity to make decisions about how they used their chair.

Care included restrictive acts that were not a proportionate response to risk. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider said everyone was able to make decisions about their care and that no-one required a deprivation of liberty safeguards authorisation.
- The provider explained that one person lived with variable memory loss. This person's relative held lasting power of attorney and had given consent for their use of bed rails. However, it was not clear whether this was lasting power of attorney for health and welfare, which is the type required for decisions about care.

The provider said they would send us a copy of the lasting power of attorney following the inspection. However, this was not received.

Staff support: induction, training, skills and experience

At our last inspection care and treatment was not provided safely because staff did not all have the necessary competence and skills. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found improvements had not been made and the provider was still in breach of regulation 12.

● People expressed confidence in the abilities of the staff, for example commenting, "No quarrels – staff know what they're doing". Staff told us they had the necessary training and were supported through supervision. However, we found shortfalls in staff training and skills that placed people at risk of unsafe care.
● Staff had not had enough fire training to know how to evacuate people safely in an emergency. We shared our concerns with the fire service.
● A senior worker had been shown how to use equipment such as hoists, standing aids and slide sheets, but was still awaiting moving and handling theory training.
● The provider and some staff lacked a grasp of the principles of the Mental Capacity Act, in relation to the person controlling their reclining chair. These were that people should be presumed able to make decisions about their care unless proved otherwise, and that people have the right to make unwise decisions.
● Staff lacked skills in managing conflicts and supporting people who were distressed. This had led to them stigmatising a person, labelling them as rude and difficult.

The provider had not ensured staff had the skills and competence to provide care safely. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider addressed some of these issues following the inspection. They informed us the members of staff concerned would have the appropriate fire training. They said they would forward a copy of their training matrix, but we have not received this.

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

At our last inspection we recommended the provider sought appropriate advice on completing comprehensive assessments and recording documentation for people. The provider had recruited an acting manager, who was tasked with improving assessments, care plans and recording. However, this had not resulted in improvements.

● People's care records did not contain a comprehensive assessment of their needs, including their social needs and Equalities Act characteristics. This meant their care plans were incomplete and they might not receive all the support they needed.
● A person's pre-admission assessment had numerous missing fields including physical and mental health, diet and nutrition, mobility and dexterity, social interests, preferred routine and religious and cultural needs.
● Most people said they were happy at the home and were positive about their care; however, another person was less satisfied. They depended on staff to help them change position and their care plan instructed staff to "pop in regularly" to check they were okay in their room. When we met them, they were

very uncomfortable in their chair but unable to readjust themselves.

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

● Staff did not always seek timely medical advice when people showed signs of being unwell. They had recorded a person had a small bleed from their bowel but did not seek medical attention.

● On several occasions another person had displayed symptoms that could be due to a serious medical condition, but staff had encouraged them to relax and slow their breathing rather than consult a doctor. The person told us, "I have seen the GP once; they seem to be frightened to call them. I've been asking to see a GP for a while as I've been feeling unwell. I've told her [a member of staff] but haven't seen one yet. I guess it's because I'm old."

● There was no systematic means of monitoring whether people were becoming constipated, despite some people being on medication that could cause constipation and on laxatives.

● A person said they had not seen a dentist since they moved in a year ago, whereas they usually had six-monthly check-ups. They said they had asked to see a dentist, but this had not been arranged. Their care records did not specify their arrangements for dental care.

The failure to seek prompt medical attention, pursue dental care and monitor for constipation represented unsafe care that placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider addressed some of these issues during and after the inspection. They advised us they would start monitoring how often people who were prescribed laxatives had a bowel motion. They advised that the person with bleeding from the bowel had a known medical condition that made this more likely and acknowledged this should have been set out in the person's care plan.

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

At our last inspection we recommended the provider sought appropriate guidance about research-based good practice for people with special diets due to swallowing difficulties. At this inspection there was no-one who with dietary needs due to swallowing difficulties.

● Most people we spoke with told us they liked the food. However, there was not usually a choice of main meal at lunch time.

● People were not always offered alternatives if they did not want what was offered. A person explained how "it took them [staff] a year" to offer an alternative to a menu item they disliked. They also told us their preferences for portion sizes were not respected: "They know I can't eat much but I get this great plate of dinner."

● People were weighed regularly to review their risk of malnutrition. People who were assessed as being at higher risk were on fortified (higher calorie) diets and some had prescribed high calorie drinks.

● No one required fluid monitoring due to an identified risk of dehydration.

● Hot drinks, but not cold drinks, were offered at intervals. A person who declined the offer of a coffee told us they were not offered hot drinks they liked. Another person told us, "We get tea and coffee at set times, I don't think we can have it when we want."

We recommend the provider consider current guidance on ensuring people are well hydrated and update their practice accordingly.

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

● The premises were decorated in a homely style. People had personalised their rooms with their own pictures, photographs and other personal effects.

● People who spent their time in communal areas indoor moved around these as they chose.

● People used a garden at the side of the building for a cream tea during the inspection. A person told us they sometimes sat in the garden during the summer. However, another person told us the garden was rarely used. Staff told us people did not use the other garden at the back of the property.

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

- Most people told us they liked the staff. Comments included, "Staff are lovely, really helpful", and, "Very nice, very good, very helpful". We observed staff speaking with people in a gentle, respectful manner.
- However, some people and staff told us certain staff were not always kind. For example, a person commented, "[Care worker] is awful with people… kind when [he/she]'s in a good mood".
- A person described their overlooked preferences. For example, they liked to relax in the bath, but were "just plonked in, washed and out you come". They said they could not have their own visiting hairdresser to maintain their hairstyle as they liked it.
- The provider and many of the staff were long established at the service. They had got to know people who had been at the home a long time.

Respecting and promoting people's privacy, dignity and independence; respecting equality and diversity; supporting people to express their views and be involved in making decisions about their care

- Staff were discreet in offering people assistance. Personal care all took place in private.
- A relative commented that most weeks on some nights there were only male staff on duty. On those nights, people would not have a choice of the gender of staff who provided their personal care.
- Asked if they had been involved and consulted in their care planning, a person told us, "Not a lot really". There was little information in people's care records of their involvement in decisions about their care.
- One person's assessment stated their faith, but their care plan made no reference to whether it was important to them to practice their religion or to how this might affect their food choices.
- We heard staff talk about what to give people for that afternoon's cream tea. Staff decided to give a person swiss roll instead of cream, as they had an unsettled stomach. There was no discussion about giving the person, who was able to make decisions about their diet, a choice.
- People could have visitors whenever they wished without notice.

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

- The standard of care planning presented a risk that people might not receive the care they needed.
- Three people's care plans made no reference to long-term health conditions that significantly affected their lives. There were no instructions for staff regarding any support the people needed to manage these.
- Some care plans lacked detail instructing staff how to meet people's needs. One person's care plan referred to "regular repositioning" to reduce the risk of developing pressure sores but did not specify how often the person required this. Another person's mobility care plan stated their blood pressure dropped when mobilising but did not say how staff should respond to this.
- One person's care plan was inaccurate, stating they ate independently but needed staff to cut their food up. We observed them readily tucking into chicken and mushroom pie with roast potatoes and vegetables, which staff had not cut up.
- Some staff talked about and delivered care in a task-focused way. One person's care plan did not contain information about their life history and interests and had little information about their preferences.
- Two people told us they liked to have a bath and used to have one weekly but had not had one for two or three weeks. One said staff told them the taps were not working, and the other said it was because the member of staff who usually did this had left.

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

The provider responded during and after the inspection. They acknowledged shortfalls in care planning, advising us that care plans would be rewritten and that there would be robust monthly monitoring of care plans to ensure these reflected people's current needs.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

At our last inspection we recommended the provider sought appropriate advice about the assessment, recording and sharing of people's communication needs. The provider had researched this and had made improvements.

● Communication needs were flagged in care plans. For example, a person's care plan and admission to hospital document (for use in the event they went into hospital) highlighted they had no hearing impairment and wore prescription reading glasses.
● People at the service were able to communicate without difficulty.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● People who were able to go out without staff did so during the inspection. However, a person with limited mobility told us they rarely if ever had the opportunity to go out: "I'd love to go on a trip. We never do anything [trips]."
● Care plans did not sufficiently address what activities people found meaningful or support they needed to pursue hobbies and interests. People told us they were not asked what activities they would like to see.
● Activities were provided ad hoc by staff or volunteers, for people in communal areas. For example, someone had their nails painted during the inspection. People said there were sometimes visiting singers, visiting animals and bingo.
● People who stayed in their rooms tended to occupy themselves with reading, listening to the radio or watching television. Following the inspection, the provider advised us they had implemented the option of one-to-one time in the mornings between these people and staff.

Improving care quality in response to complaints or concerns
● The provider kept a comments, complaints and suggestions book for people to write their comments in, and the provider to make their response. The most recent entry was dated April 2018.
● This complaints book was in the provider's office, but the provider informed us it should have been in the reception hall.
● Although the book provided a means for people to raise concerns, the service needed a confidential complaints process. The provider advised us they would put this in place.
● A person said they had told staff about their concerns regarding their care and they said they would sort it out. None of these concerns were reflected in the complaints book.

End of life care and support
● No-one was at the end of life during the inspection.
● Where people had preferences in relation to the end of their life, these were recorded. When people had not expressed any preferences, staff sensitively revisited this on occasion.
● Some people had 'do not attempt cardio-pulmonary resuscitation' notices in place, as they did not wish to be resuscitated if their heart stopped.
● The service had received compliments from relatives about the care their deceased loved ones had received as they approached the end of their lives.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant there 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; Continuous learning and improving care; Working in partnership with others

At our last inspection the provider had failed to ensure systems and processes were established and operated effectively to meet the regulations. Records were not available or complete. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found improvements had not been made and the provider was still in breach of regulation 17.

● The provider and staff had worked in cooperation with the local authority safeguarding and contracts teams. However, this had not resulted in the expected improvements in care. Indeed, the quality of the service provided had deteriorated.
● The service is in special measures. Even so, the provider had not taken effective action on the requirement notices and some recommendations from the last inspection to ensure people received safe and effective care in a well-led service.
● The provider's audits and quality assurance processes did not identify the breaches of regulations found at this inspection, nor multiple concerns identified at a recent local authority visit.
● Records were incomplete and some lacked detail. The provider repeatedly told us files were not in order. They were unable to provide in good time all the information requested. They said the acting manager had archived records that should have been kept on files, and that there was a lot to rectify.

Systems were either not in place or not robust enough to manage the safety and quality of the service. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They started working on the files, but these still did not contain the necessary records by the end of the inspection. They said they would add a member of staff's reference to their staff file but had not done so by the end of the inspection.

At our last inspection the provider had not made statutory notifications of significant incidents, such as safeguarding concerns. CQC uses information from notifications to support their monitoring of services. This

was a breach of regulation 18 (Notification of other incidents) of The Care Quality Commission (Registration) Regulations 2009.

At this inspection we found the provider was no longer in breach of regulation 18.

● Statutory notifications had been made in relation to expected deaths. Notifications would have been expected for the safeguarding incidents, had the provider identified these as such.
● However, following the last inspection, the provider, who was also the registered manager, had appointed someone to manage the service; this person had left shortly before the inspection. The provider had not notified CQC of the change in management arrangements.

We recommend the provider ensures they understand the requirement for statutory notifications about the absences of registered persons for 28 days or more, and for changes affecting a provider or manager. These are covered by regulations 14 and 15 of The Care Quality Commission (Registration) Regulations 2009.

● The rating of inadequate from the last inspection was not shown on the provider's website and was not on display when we arrived at the service.

The failure to display the rating was a breach of regulation 20A (Requirement as to display of performance assessments) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during the inspection. They displayed the rating in the hallway by the visitors book, where everyone could have access to it. However, the rating was still not displayed on the provider's website.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● There was a friendly and informal feel. Most people we spoke with said they were happy at the service. A person commented, "I feel safe living here as it's only small. It's mostly family who run it, so it feels like a big family. I prefer it here to the last place I lived."
● However, the culture of the home was not open. There was no action when a member of staff raised concerns about poor practice in supervision. A person described a lack of action when they reported a member of staff whose practice they were concerned about.
● There was a lack of clarity around leadership roles. Staff did not all know who the senior care workers were. When asked about morale, staff said, "I feel we're at a difficult point [changes in management] but all the staff have worked together".
● A relative and a person living at the service commented on there being frequent changes of staff. Until the last inspection, the service had had a stable staff team.
● Whilst some people who were mobile regularly went out, there were no other community links.
● The provider spoke informally with people and staff, but there was no clear mechanism for ensuring they were meaningfully involved in decisions about the service.

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
● No incidents that the provider identified had required them to act on the duty of candour.