Bindon Care Ltd

Bindon Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service:
Bindon Residential Home provides accommodation for up to 42 people. The service provides care for older people; most of whom are living with dementia. The home is separated into two different areas called Bindon and Elmcroft. At the time of our visit 33 people were living at the service.

People's experience of using this service:
•□Systems and processes to monitor the service were not effective, did not drive improvement and the provider had poor oversight and had not identified this. As a result, the quality of care provided to people had deteriorated since the last inspection.
•□People's health, safety and welfare were put at risk because there were not always sufficient numbers of suitably qualified, skilled and experienced staff on duty.
•□The provider had not ensured staff were suitably trained and sufficiently supervised. As a result, the staff team did not have the skills to support people effectively and people had been exposed to the risk of harm.
•□The service was not safe because people were not always protected against the risks associated with medicines.
•□People's nutritional needs were not always identified and monitored. Nutritional care plans lacked detail or clear instructions for staff about how to support people in relation to eating and drinking, especially where they were at risk of weight loss. Records relating to people's daily dietary and fluid intake were poor. This meant we could not tell in any detail what people had to eat each day
•□People were at risk because accurate records were not consistently maintained. There were gaps in people's repositioning and personal care records. We could not be assured people's care needs were being met consistently.
•□Care records did not always reflect the needs and preference of people using the service. They were contradictory in places. The lack of detailed and accurate care plans meant care and support may not be given effectively. Visiting healthcare professionals shared similar concerns.
•□There was a lack of stimulation for people using the service. Several people said they would like to see improvements in this area. Very few activities were offered and those that were did not always take into account individual interests and preferences or consider individual's abilities.
•□Some equipment and aspects of the premises were not clean. Poor infection control standards were found throughout the service.
•□Some environmental risk had not been identified.
•□We saw positive interactions during the inspection, with staff being kind, friendly and patient when assisting people.
•□People enjoyed the meals provided.

Rating at last inspection:
At the last inspection the service was rated as requires improvement (February 2018). The service had been rated as requires improvement for a third consecutive time. At this inspection we found the service had

deteriorated and is rated as inadequate overall.

Following the last inspection, asked the provider to complete an action plan to show what they would do and by when to improve the key questions of safe and well-led to at least good. We also met with the provider to confirm they were following their action plan to ensure improvements were made.

Why we inspected:
We brought this comprehensive inspection forward as we had received concerns from a variety of sources that included community health and social care professionals, anonymous whistle blowers and family members. Concerns included poor staffing levels, poor standards of personal care, poor management of risks, unsafe staff recruitment practices, poor standards of cleanliness and a lack of stimulation and occupation for people. As a result of the mounting concerns, Devon County Council implemented a whole service safeguarding process in January 2019. There were also several individual safeguarding investigations in progress. Placements to the service have been suspended by Devon County Council because of the safeguarding concerns. The provider has voluntarily suspended admissions of privately paying residents. At the time of the inspection we were aware of two incidents being investigated by third parties.

Enforcement

During the inspection we identified nine breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were at risk from harm because the provider's actions did not sufficiently address the ongoing failings. There has been ongoing evidence of the provider to sustain full compliance since 2015. Our findings do not provide us with confidence in the provider's ability to bring about lasting compliance with the requirements of the regulations.

Follow up:
During the safeguarding process the service is being monitored through a combination of visits by health and social care staff, as well as multidisciplinary safeguarding strategy meetings. Due to concerns about fire safety, we made a referral to the Devon and Somerset Fire Service.
In addition, we requested an action plan and evidence of improvements made in the service. This was requested to help us decide what regulatory action we should take to ensure the safety of the service improves.

The overall rating for this registered provider is 'Inadequate'. This means that it has been 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.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This 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. This will lead to cancelling their registration or to varying the terms of their registration.

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. We will have contact with the provider following this report being published to discuss how they will make changes to ensure the service improves their rating to at least Good.

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.

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective

Details are in our Effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive

Details are in our Responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our Well-Led findings below.

Bindon Residential Home

Detailed findings

Background to this 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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted in part by a notification of an incident following which a person using the service died unexpectedly. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident.

However, the information shared with CQC about the incident indicated potential concerns about the management of risk of falls and the use of equipment to reduce risk. This inspection examined those risks.

Inspection team:
This inspection was carried out by two inspectors, a medicines inspector and an inspection manager.

Service and service type:
Bindon is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have registered manager. The previous registered manager had left the service in November 2018 and cancelled their registration with us. A new manager had been appointed in November 2018, however they had not yet registered. A registered manager is a person who has registered with the CQC to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
The inspection was unannounced on the first day. Inspection site visit activity started on 6 February 2019 and ended on 14 February 2019. On 11 February 2019 we completed a late-night unannounced inspection.

What we did:
Prior to the inspection we reviewed the information we hold about the service. This included information shared with us by the local authority, health and social care professionals, family members and whistle blowers. We reviewed notifications we had received from the service. A notification is information about important events which the service is required to send us by
law.

Some people using the service were living with dementia or illnesses that limited their ability to communicate and tell us about their experience of living there. 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 speak with us and share their experience fully.

During the inspection we met with the majority of people using the service and spoke with 13 of them. We also spoke with five relatives, the company director and manager and 12 staff. We met two health professionals during the inspection. We reviewed six people's care files; three staff recruitment files and training and supervision records; audits and policies held at the service. We looked around the premises. Following the inspection, we received feedback from one relative, six health and social care professionals as well as feedback from the whole service safeguarding meetings.

Inadequate

Is the service safe?

Our findings

At the last inspection this key question was rated as 'requires improvement' as the service was not consistently following safe practice in relation to medicines management. At this inspection the rating had deteriorated to inadequate due to a number of failings.

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

People were not safe and were at risk of avoidable harm. Some regulations were not met.

Some people said they felt safe in the service however, despite this feedback we found significant concerns about the safety of the service.

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

- One person had experienced a number of falls. There was conflicting information in their care records. They had been assessed as a high falls risk in December 2018 yet in another part of the care plan it said no falls in the past year. However, they had six falls in January 2019. A referral had been made to the falls team for advice but there was a six to eight week wait for their input. In the meantime, the care records had not been up-dated with any additional measures to reduce the known risk.
- There had been a number of falls, injuries and incidents at the service since the last inspection, however, staff had not received training in falls awareness and prevention. This demonstrated a lack of recognition of the risks by the provider and a failure to ensure staff had the skills and competence to mitigate risks to people.
- Pressure relieving equipment was used for people who presented with a risk of skin damage. However, there was no guidance in care records about the inflation setting for each mattress. One person had the mattress set too low according to their weight. Another person was to be weighed on a weekly basis to ensure the mattress was on the correct setting for their weight. No weight had been recorded since December 2018. This increased the risk of people developing pressure damage.
- Visiting professionals reported that the early signs of skin damage were not always being recognised and adequately managed to reduce the risk of more serious damage developing.
- One person required regular two hourly repositioning according to their care plan. Daily records showed this was not consistently done or recorded, with gaps of up to seven hours where the person was not repositioned according to supporting records that would evidence care delivery.
- The care plan stated this person was to have cream applied to their sacrum every four hours. The records showed significant gaps; on one occasion cream was applied just once during the day. On other occasions the gap between recorded applications was almost eight hours.
- One person's records showed they were diabetic. In the care plan it stated their blood sugar measurements should be done on a weekly basis. However, records showed the person's blood sugar had only been monitored four times since September 2018. This meant the person may not be receiving the care and support they required.

The above concerns demonstrated a failure to prevent avoidable harm or risk of harm which was a breach of

Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Records showed the number of falls had decreased since September 2018. The falls policy had been up-dated to ensure timely referrals had been made to the local falls team. Where necessary and appropriate, referrals had been made to the falls team following any initial fall.
● A relative explained the service managed the risk of falls for their relative well, without restricting their independence, movements or over using sedatives. They added, "They have done as much as possible to reduce (person's) risk. She is in a good place…"
● Permanent staff were aware of people who were at risk of falling and which people required the movement sensor equipment to reduce the risk. Agency staff were not aware.

Staffing and recruitment
● There were not enough qualified, skilled and experienced staff on duty to meet people's needs or to ensure the service was clean and hygienic. The provider had failed to demonstrate they had carried out a needs analysis and risk assessment as the basis for deciding sufficient staffing levels.
● People, staff and relatives told us there were not enough staff. Comments included, "I think they are a bit short of staff"; "They need more staff. Visiting Dad now I spend most of my time doing the jobs that should have been done" and "There's been a high turnover of staff…agency staff don't know (person)". A professional said, "I wouldn't want any of my family here, there are not enough staff".
● A review of the rotas from 7 January 2019 to 11 February 2019 showed several occasions when the preferred staffing levels were not met. This was usually due to short notice sickness and lack of availability of agency staff.
● As a result of staff shortages, staff explained that people's personal care was sometimes delayed and people had to wait for staff to respond to requests for support. A member of staff said, "We are pulled in all directions…" Family members reported a lack of staff presence in communal areas to ensure people's needs were met and they remained safe.
● Some people displayed behaviours that challenged and could potentially cause harm to others. One person required close monitoring. Their care plan stated, "I must be supervised at all times while I'm in communal spaces". We found this person's whereabouts were not always being monitored due to a lack of staff presence in communal areas, placing other people using the service at risk of being subjected to this challenging behaviour. The additional support required had not been considered in relation to the overall staffing levels.
● There was a lack of meaningful interaction between people and staff. Some people remained in their bedroom for all or most of the day. Except for staff completing tasks, such as personal care or serving their meals, staff did not have much time to spend socialising with or reassuring people.
● Housekeeping or cleaning staff were not available every day, meaning the care staff had to undertake these duties. On occasions a cook was not available and care staff were expected to ensure meals were prepared in addition to their primary role of care provision. Care staff were also responsible for doing the laundry. This meant care staff were not always available to ensure people's needs were met in a timely way.
● The service had experienced staffing problems in the past few months. There had been a high turnover of staff and a reliance on agency staff. Agency staff explained they were not always given a detailed handover about people's needs and relied on staff on the floor to guide them. Regular agency staff were used to improve consistency.

The failure to effectively employ a sufficient number of suitably qualified and skilled staff was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some staff were recruited from an employment agency. The provider had requested the agency send

references for staff and provide a Disclosure and Barring Service (DBS) check. However, this had not consistently happened. One person had been allowed to live at the service on a temporary basis without an up to date DBS check. They had access to vulnerable people and therefore this was a risk. When the check finally arrived, it contained concerning information. The provider immediately dismissed the person and they left the service.

The failure to operate robust recruitment procedures was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had followed procedures for safe recruitment practices for three staff recruited recently.

Preventing and controlling infection
● People were not adequately protected from the risk of infection. The environment was not clean and was malodorous in several places.
● Visitors commented on the poor standard of cleanliness. Comments included, "(Person's) room is often dirty and smells…" and "There's a lack of attention to cleanliness…"
● There were insufficient housekeeping staff employed to ensure the service was clean and hygienic. A cleaner said there was not enough cleaning equipment, no mirror cleaner and only one polish for the whole house.
● Health and social care staff reviewing people's care reported that one person was being washed with a flannel "covered in faeces".
● Several en-suite toilets were heavily soiled with faecal matter. Several bedrooms had an offensive smell of urine and faeces. Bedroom floors were dirty, as was furniture.
● A clinical waste bin in a bathroom was overflowing with offensive materials and the bin did not have a lid. Soiled continence products were found in one person's en-suite. This should have been disposed of within the clinical waste bin.
● During our night visit the laundry room was overwhelmed with dirty linen. Some items were heavily soiled and left on the sink area. Laundry trollies and baskets were overflowing with washing. Dirty washing was piled up and around the sink area, meaning staff could not wash their hands easily.
● Staff did not always have access to sufficient protective equipment, for example aprons. We observed two staff assisting a person who had been incontinent of faeces. Although they used gloves they did not use aprons.
● Some staff were unaware of where the store of aprons and gloves were kept. Once brought to the attention of the senior on duty, aprons and gloves were supplied to staff.
● A visiting professional raised concerns about infection control standards, saying, "There is a lack of gloves and towels in people's rooms..."
● Eight staff had not completed infection control training or their refresher training was overdue.

The failure to protect people from the risks associated with the spread of infections was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Using medicines safely
● Peoples medicines were not always managed safely.
● We found issues with the accuracy of eight out of 15 people's Medicines Administration Records (MARs) that we checked. These records showed that it was not always possible to be sure that people received their medicines in the way prescribed for them, placing them at risk.
● One or more doses of medicines had either not been recorded as given, or it was not clear if doses had been given as prescribed. For two of these people one or more doses of their medicines had been signed as

given but the doses remained in the blister packs, evidencing they have not received their medicines as prescribed despite a record being made by staff indicating it had.
● There was information in people's care plans for medicines prescribed 'when required' to guide staff when it would be appropriate to administer doses. For some medicines there were also separate protocols kept with the medicines records, but this system was not consistently used.

This demonstrated a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The checking procedures had been improved and some issues with the administration and recording of medicines were being identified.
● There were suitable arrangements for ordering, receiving, storing and disposal of medicines, including medicines requiring extra security
● There were systems for checking, auditing and reporting any medicines issues. Some areas for improvement had been identified and addressed. Some of the issues and areas needing improvement that we found had been identified for improvement and plans were in place to address these issues. Further training was being arranged for staff, and the manager said this would be followed by competency assessments to check staff gave medicines safely.

Environment and equipment:
●The premises were not maintained to a safe standard and we found several potential safety hazards.
● Fire safety was not well managed. Weekly fire door checks had been carried out, however, we found several fire doors did not close properly. This meant the doors would not have prevented the spread of fire or smoke in the event of an emergency.
● Regular fire safety checks had not been completed. Fire panel control checks had not been completed since October 2018. The fire alarm tests for October 2018 had not been completed.
● The provider had a fire risk assessment completed by an external professional in March 2017. They explained the recommendations made were being implemented. For example, replacing heavy fire extinguishers. However, there were several of the older style heavy extinguishers still in use. The provider said they had reviewed the fire risk assessment, but did not keep written records of the review.
● Not all staff had up to date fire safety training. We have made a referral to the Fire Service for them to follow up the concerns.
● Not all equipment was properly maintained, suitable for its purpose or used correctly. For example, some divan beds were too low, putting people and staff at risk. Chair heights for some people were inappropriate. Hoist slings had not been serviced since 2016. This put people at risk of harm.
● During our night visit there was no hot water in Elmcroft. It had been switched off by the plumber and staff said they didn't expect it to be back until the following day. We saw staff struggled to support a person who had been incontinent of faeces without access to hot water. They had to use the kettle in the kitchen to boil water.
● An old linen room in Elmcroft was open despite having a key coded lock. There were
a variety of objects on the floor causing a trip hazard. Floorboards had been taken up with resultant holes in the floor, causing a hazard. Hot water pipes were exposed causing a risk of burns.
● The provider had introduced regular monitoring of water temperatures to reduce the risk of scolds. However, there were two baths where the water temperature was above that recommended by the Health and Safety Executive (HSE).
● Several radiator covers in communal areas and people's bedroom were loose or falling off the wall. This presented a hazard.

The provider had failed to ensure the premises were safe which was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The provider had invested a significant amount in the building since the last inspection. For example, several windows had been replaced; a new central heating boiler had been installed; new flooring was being laid in Elmcroft and new dining room chairs had been purchased.

Systems and processes to safeguard people from the risk of abuse

● Staff demonstrated an understanding of what constituted abuse and how to report concerns to the manager, provider or the Care Quality Commission (CQC). Some staff were not aware of the role of the local authority or that they could contact them directly. The manager was fully aware of her responsibility to inform the local authority and the CQC about any safeguarding concerns.

● The provider and manager were working with the local authority safeguarding team during the current whole service safeguarding investigations.

● Records showed several staff required safeguarding training or a refresher.

Requires Improvement

Is the service effective?

Our findings

At the last inspection this key question was rated as 'Good'. At this inspection the rating had deteriorated to 'requires improvement'.

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.

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met

Staff support: induction, training, skills and experience

● People, or those acting on their behalf, could not be confident the staff had the knowledge and skills to carry out their roles and responsibilities. This was because staff had not received regular training, supervision or appraisals to support them.

● The majority of people we spoke with did not comment on staff competencies. Two relatives expressed concerns about some staff's understanding of their loved ones, who were living with dementia. Comments included, "There's been lots of staff turnover. New staff and agency don't know or understand Dad…"

● A community nurse raised concerns about staff's understanding and management of pressure areas and minor skin damage. Occupational therapists raised concerns about the way some people were assisted to move, especially when using equipment.

● There had been a high turnover of staff. The training matrix showed staff required training in several areas, particularly new staff. The manager and provider confirmed training for staff had not been completed in line with their training policy as they were sourcing a new training provider.

● A member of the housekeeping team explained they had received a one-day induction with the manager. This covered some basic policies, but they had not received training relating to their role, for example, the control of substances hazardous to health (COSHH regulation) or infection control. This posed a risk to people living at the service and to the staff member.

● An infection control audit completed in December 2018 identified that training was required for cleaners.

● Some staff required training relating to dementia care and challenging behaviour to help them work safely and effectively with people living with dementia. During a group activity we observed practice that showed improvements to staff skills were required. Although staff were kind and well-meaning, some spoke over people and talked about themselves and others rather than involving everyone in the activity and discussion.

● New staff were not receiving a comprehensive induction to help them work safely with people. The manager explained new staff had received a one-day induction with her, although no records were kept of the topics covered. The manager said staff engagement with the Care Certificate (a nationally recognised induction training for staff new to care) was poor. Therefore, a decision was made to abandon the Care Certificate and cross reference in-house training to ensure all essential topics were covered. However, this approach had not been implemented at the time of the inspection. One new staff member said that the one day induction with the manager was very good.

● Staff supervision had lapsed. Supervision provides an opportunity for staff to discuss their work and

training needs and to receive feedback about their performance. The manager had introduced a new format for supervision but had not had time to fully implement it. Only four staff had received supervision since July 2018.

The provider had not ensured staff were suitably trained and effectively supervised which was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities).

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

● People were not always supported to ensure they had sufficient amounts to eat and drink and to maintain a balanced diet. Three people had lost weight, which required further monitoring or intervention by a healthcare professional.

● There had been a delay in informing the GP about one person's weight loss. The GP confirmed the referral was made following our inspection, although the person had been losing weight over a period of months prior to our inspection.

● Another person had been prescribed nutritional supplements in December 2018 but these had not been reordered so were not available to the person. This placed them at further risk of weight loss. Their care plan gave conflicting information regarding their diet. In one place it said a 'normal diet', in another it stated to give high calorie drinks.

● Weights were not monitored regularly to ensure timely action was taken to reduce risks. The care plan for one person said they should be weighed weekly. Records showed only monthly weights had been maintained and there was a gap of 6 weeks where their weight was not monitored. Another person required monthly Mid-Upper Arm Circumference (MUAC) measurements to be carried out monthly, as an alternative method to establishing their risk of malnutrition. There was no record to confirm the MUAC had been completed.

● The food and fluid charts for two people at risk of weight loss were poorly completed. There were days where no entries were made or entries were incomplete or minimum information was recorded. This meant we could not tell what the person had to eat each day, or whether they were being offered alternative snacks or food supplements, if they declined meals.

● Not drinking enough raises the risk of developing infections and falling due to dehydration. Seven people had suspected or confirmed urinary tract or chest infections since January 2019. As records were poorly completed it was difficult to confirm if people had been given enough to drink.

● People did not have a pleasant dining experience on the first day of the inspection. Due to a problem with the oven lunch was delayed. However, people sat at the dining table from 12.30pm until after 2.30pm when their meal arrived.

The provider had failed to ensure people's nutritional and hydration needs were met, which was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Most people said they enjoyed the food. Comments included, "The foods very good, all freshly cooked and we get plenty to drink"; "The staff give us good cooked food"; "All the food is delicious" and "I haven't had a bad meal yet. Everything we have is nice and tasty".

● People were offered regular drinks.

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

● People had access to health professionals in order to meet their health care needs.

● GPs and other health professionals said it was not unusual to arrive at the service having been requested

for a visit and for specific details around care not to be immediately available from an informed member of staff. They said there were also inconsistencies between what doctors were told and what was then evidenced in the care notes and medicine charts.

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

●The provider had not ensured the decoration and layout of the building was in line with best practice guidelines around dementia friendly environments. They had not taken steps to ensure that the internal décor of the building was maintained, refreshed and homely.

● Relative's comments about the environment included, "The place looks tatty and is well over due for redecoration…" and "We did feel that the place was homely when (person) first moved in. Now it looks shabby and dirty…"

● The premises were in need of redecoration and refurbishment. Carpets were stained in places (in the lounge, bedrooms and corridor areas) and the walls had peeling or chipped paper and various marks, which did not look homely. The company director explained there was no on-going plan in place for internal improvements to the environment, rather the maintenance person dealt with issues as they arose.

● Best practice was not followed for people living with dementia. National good practice in dementia care, such as that produced by the University of Stirling, suggests buildings accommodating people living with dementia should be designed and decorated in a way that supports people. For example, the good practice guidance highlights doors should be in a contrasting colour as should toilet seats and handrails and there should be easy to read signage.

● Some bedroom doors were only numbered with no names or features to help people distinguish one room from another. Colour was not used to define areas to assist people's independence and way-finding.

● The carpets in Bindon were patterned, as were some chairs and curtains. Patterned flooring can result in an increased risk of falls and raise stress levels for people living with dementia. The flooring in the corridors of Elmcroft were being replaced with a plain laminate floor, which would reduce this risk.

● There was signage around to help people to orientate themselves, but this was not always accurate. For example, the dining room had a sign saying lounge. On the first day of the inspection the reality orientation board in Bindon lounge said Saturday when it was Wednesday. This meant information provided to people living with dementia to orientate themselves around the home was not clear and could cause confusion.

● Elmcroft did not have a communal shower. There was an assisted bath on the first floor but two people were unable to use it as they exceeded the weight for the hoist. Staff explained these people had to go to Bindon for a bath or shower. Staff said they were reluctant to move people via the garden in the cold weather but this was the only way to access the bathing facilities.

The provider had failed to ensure the premises were suitable to meet people's needs, which was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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

● Prior to moving to the service, people's needs and choices were assessed by the manager, to ensure the service was suitable for them. The manager also gathered any additional information from professionals to aid the assessment process. However, the manager said some information shared with her about people's needs had not been accurate. This had led to one person being moved from the service as their needs could not be met. Another person had been given notice as the service struggled to meet their needs.

● Care was not always delivered in line with good practice guidance. For example, care of people with weight loss; those with diabetes and those living with dementia.

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

We checked whether the service was working within the principles of the MCA, and whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

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

- Records showed people's capacity to consent to various aspect of care or treatment had been assessed. Where a person lacked capacity to make a decision, a best interest decision had been made with family members and other professionals, such as social workers or GPs. For example, best interest decisions had been made on people's behalf in relation to living at the service; the use of sensor mats; administration of medicines and personal care.
- Appropriate applications for DoLS had been made to the supervisory body when necessary.

Requires Improvement

Is the service caring?

Our findings

At the last inspection this key question was rated as 'Good'. At this inspection the rating had deteriorated to 'requires improvement'.

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

People did not always feel well-supported, cared for or treated with dignity and respect.
Regulations may or may not have been met.

Respecting and promoting people's privacy, dignity and independence;
● People and their relatives said staff were kind and caring and were trying their best to support them. However, we observed people were not always well-supported, cared for or treated with dignity and respect.

● People's personal care was poorly attended to and most people appeared dishevelled. Several people were in dirty, mismatched and un-ironed clothes. People had long dirty finger nails and mouth care for some was poor.
● Relatives raised their concerns with us about the poor standard of personal care. One said their family member had spent three days and nights in the same clothes as staff were unable to encourage them to change and except personal care. They added, "…he stinks of wee…" They said the person's finger nails and toes nails were "disgusting…"
● Another relative recounted an occasion when their loved one was incontinent of faeces and staff suggested they change the person after they had eaten their lunch.
● People did not always get their clothes back from the laundry. One relative said they had taken "…two binbags of clothes from my (person's) wardrobe…that are not his. This is not the first time either. I am not alone on that one…On occasion there are dresses, skirts and blouses in his wardrobe…"
● Staff said there was often no personal care products, flannels and towels in people's bedrooms when assisting people with their personal care. One said, "One lady had no pads in her room, all she had was a toothbrush and toothpaste, when I came back several days later she still didn't have any toiletries… Another resident didn't have any soap, it's a recurring issue and it's so irritating. You go to someone's room and you have to run around looking for essentials."
● We visited a person in their room, who was laying on bed with no bedding, wearing a dirty tee-shirt. There was faeces on the toilet seat, which remained there when we visited the person again in late in the afternoon.
● Some staff were not discrete and discussed people's care needs in the communal areas, including who needed assistance with using the toilet. This did not respect people's privacy or promote their personal dignity.

Ensuring people are well treated and supported; equality and diversity
● The care planned and delivered was not personalised to reflect people's likes, dislikes and preferences. There was a risk the task orientated approach to care may impact on people's individual preferences and

wishes.
● Due to the staffing levels staff did not have time to spend with people other than when delivering care. This meant people had few social opportunities or opportunities to explore new experiences. Some people said they were bored and had little stimulation or variety within their day.
● We observed one person in Elmcroft slumped over a table in the dining area. They were there for several hours. There was very little personal intervention from staff and no offer to move the person to a more comfortable position.
● Another person and their relative explained that other people often visited their bedroom uninvited during the day and at night and disturbed them and their belongings. This was up-setting for the person. Staff had not protected the person from unwanted visitors.
● One care worker said to a person, "Let's lift your feet up", but then moved their feet before they had time to register it.

This showed a lack of understanding of how to provide considerate and dignified care to people living with dementia which was a breach of Regulation 10 of the Health and Social Care act 2008 (Regulated Activities) Regulations 2014.

Supporting people to express their views and be involved in making decisions about their care
● Some staff showed a lack of knowledge relating to people's individual preferences and people were not fully involved about decisions. For example, loud 'pop' music was playing in the lounge area of Elmcroft and in some people's bedrooms. People had not been asked what music or radio station they would like to listen to. One person said, "I don't like it here, they just put this music on…"
● Due to the nature of people's conditions regular resident's meetings were not held. There was no mechanism in place to hear the experiences, thoughts and feelings of people using the service.

● In contrast to the above examples, we heard from people that staff were kind and friendly. Comments included, "The people who live here are lovely. The staff are lovely, they are kind",
"It's lovely here… I think the staff are kind. One day I fell over and the staff came and helped me up. Sometimes they do seem rushed"; "It's OK here, I've been here four weeks. I get medicine every day. The staff treat me very well" and "I am treated with respect".
● Two relatives expressed confidence and satisfaction in the service. Comments included, "I think it's a brilliant service for (person). They are very caring here and give people the freedom to be individuals…I have never seen anything to concern me…" Another said, "…nice care staff, they are very kind. (Person's) anxiety has reduced since being here…"
● The manager and staff expressed a commitment to providing good care and treating people well.
● We observed several instances where staff showed kindness and compassion towards people. For example, during our night visit two people were unsettled. Staff made them tea and toast and settled them comfortably in the lounge. A member of staff was particularly skilled with one person who was unsettled and offered them a hand to have a stroll around the premises.
● Night staff confirmed people could get up and go to bed at a time of their own choosing. During our late night visit we saw this was the case.
● Some staff had really good skills in communicating with people, for example in explaining the different choices at mealtimes and spotting when people needed assistance.
●Some staff showed good empathy and kindness and expressed their concerns they couldn't spend time with people because of staffing levels.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection this key question was rated as 'Good'. At this inspection the rating had deteriorated to 'requires improvement'.

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

People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

● Care records did not always reflect the needs and preference of people using the service. They were contradictory in places and some were overdue a review according to the computer-generated care planning system. Care plans are a tool used to inform and aid staff about meeting people's health and social care needs.

● Occupational therapists (OTs) had been involved in reviewing moving and handling plans as part of the whole service safeguarding process. They told us some staff were skilled and competent. They had observed staff moving one person with very complex needs with care. However, concerns were identified with the care records and moving and handling plans, as they lacked detail and did not describe the correct equipment and sling to use for each individual, comments usually read "Hoist with two carers".

● The behaviour plan for aggressive behaviour was limited for one person. Triggers had been identified but the only advice to staff when faced with aggression was "maybe leave him and go back and try again". Their relative explained that as a result of staff turnover, new and agency staff did not understand how to approach their loved one to ensure their care needs were met.

● Most people would not be able to fully participate in the planning of their care. Relatives confirmed they had been involved initially but felt their comments and suggestions were not always acted on. For example, one relative explained they arranged regular outings for their family member. Staff were always informed of when outings were arranged but often the person wasn't ready, or was inappropriately dressed or not wearing continence products they needed. They added, "There is a general lack of attention and care…"

● People's care needs were not effectively communicated to staff, especially to agency staff. Some staff had not seen people's care plans and relied on a verbal handover for information. As a result, people did not always receive care in accordance with their care plans. For example, some people were not appropriately supported with moving and handling.

● Records of daily interventions were sometimes brief and repetitive. For example, there were days when nothing was recorded about the personal care delivered or offered. Some generic statements were made, such as, "Checked, was awake, was happy" and "Dressed, needed help most of the time, was content." The records did not provide a full picture of the care and support provided.

● There was a lack of stimulation and occupation for people using the service. One person said, "There used to be a lot of activities, not so much anymore".

● The activities co-ordinator had left the service since the last inspection and not been replaced. ● The manager was developing the role of "home-maker" to provide daily engagement and occupation. The plan

was to involve people in day to day activities, such as preparing vegetables and light household chores, as well as activities to reflect their hobbies and interests. However, this had not been fully implemented.
● Care records contained details of people's past hobbies and interests. However, they did not have the opportunity to engage in old hobbies or develop new ones.
● Few activities were offered and those that were did not always take into account individual interests and preferences or consider individual's abilities. During the course of the inspection we saw one group discussion relating to the current news. Due to the nature of people's condition, it was difficult for some to participate.
● Some people spent the majority of time in their room, which put them at risk of social isolation.
● Staff said they had little time for socialising with people or supporting them with activities of their choice. One said, "It's sad really. We just don't have the time to stop. I think people are bored…"
● We looked at the activity records for everyone at the service. These showed people mainly watched TV; stayed in their room; were "taken to the sitting room" or had a visitor. Records showed only one person had spent time outside of the service in the past month.
● Three relatives commented on the lack of activities and stimulation. One said, "I think it is depressing to sit all day with nothing of interest to do. I haven't seen any activities over the past few weeks…"

● Some staff were very responsive to people's needs. For example, one person was coughing badly and staff were extremely attentive and took prompt action to help and reassure them.
● One relative said "They look after my relative nicely".
● There were some exercise activities that took place during the inspection, which people did enjoy.

●We looked at how the provider complied with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 which requires the service to identify; record and meet communication and support needs of people with a disability, impairment or sensory loss.
●Care plans provided information about people's sensory or hearing impairment. However, the care plan was not always followed to ensure people had equipment they needed to enhance communication. For example, a relative said their family member had been without their glasses for six months.

The lack of person centred care was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Improving care quality in response to complaints or concerns
● The provider had a complaints process in place and people were aware of how to raise their concerns.
● Some people were not fully confident the provider would respond to their concerns and complaints. Three people had contacted us as they had been unhappy with the response the provider had given to their concerns. People did not feel listened to and felt no action was taken following their complaint.
● Four complaints had been received by the service since the last inspection. Themes included lack of staff; lack of person centred care and cleanliness. Although all had been responded to, some people were dissatisfied.
● The provider had not used complaints to monitor trends over time so that improvements could be made. At this inspection we found the themes from complaints were still evident and the necessary improvements had not been addressed.

A failure to monitor themes from complaints and make improvements was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

End of life care and support

● One person was receiving end of life care during the inspection. They had a Treatment Escalation Plans (TEP) in place, which recorded important decisions about how they wanted to be treated when their health deteriorated. This meant the person's preferences were known in advance so they were not subjected to unwanted interventions or admission to hospital at the end of their life, unless this was their choice.

● The end of life care plan on the electronic care planning system had not been fully completed about how to deliver the person's daily care, including mouth care and position changes. However, we saw the person was comfortable in bed. Staff visited the person to ensure they were comfortable; a mouth care kit was being used and their position was changed regularly.

Inadequate

Is the service well-led?

Our findings

At the last inspection this key question was rated as 'requires improvement' as governance arrangements had not consistently identified shortfalls in relation to the management of medicines, and environmental risks relating to the hot water temperature and fire doors needing remedial work. At this inspection the rating had deteriorated to inadequate due to a number of failings.

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

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility

- Leadership and management did not ensure person-centred, high quality care was delivered. The provider had failed to ensure there was sufficient oversight and governance at the service. Systems had not been effective in identifying shortfalls and unsafe practices. As a result, standards had declined since out last inspection. The provider was not aware of many of the concerns we raised during the inspection.
- People were not protected from varying staffing levels as the provider had not completed a needs analysis and risk assessment for the basis of deciding sufficient staffing levels.
- Recruitment practice put people at risk as the necessary checks had not been obtained prior to staff being allowed to move into the service.
- Due to poor monitoring systems, issues relating to weight loss not been acted on in a timely way to protect people from these risks.
- People were at risk because accurate records were not consistently maintained. There were gaps in people's food and fluid charts and repositioning and personal care records. We could not be assured that people's care needs were being met. In light of these inconsistencies in recording care interventions we asked the manager and senior care staff if there was a reason why these things had not been recorded. They explained there was a shortage of electric 'pods' on which to record interventions and if you were out of range the Wifi signal records would be lost. An external professional had checked the Wifi and the provider said staff had been told to continue to enter care interventions, which would be picked up once the 'pod' was within range of the Wifi.
- People's complaints were not always actively listened to and were not always responded to appropriately and they were not used to drive improvements across the service.
- Handover and communication systems were ineffective and important information was not always being effectively shared between shifts, especially for agency staff. These failings had exposed people to the risk of harm and had resulted in poor standards of care being delivered.

The shortfalls in governance and failure to implement improvements was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● The service had experienced an unsettled period due to a change in management and staff turnover. The impact of this had not been adequately assessed or planned for by the provider in order to ensure people received safe, effective, responsive care.

● A new manager had been appointed in November 2018, however they had not yet registered with the Care Quality Commission. The manager did not have the support and resources available to her to make the necessary improvements.

● The manager had not received appropriate support within their role. They had not received formal supervision from their line manager since starting at the service in June 2018. However, she did meet regularly with the company director.

● The provider had not ensured there was an effective management structure in place to monitor the care provided. They had also failed to ensure staff were given the support they required to provide safe, effective, responsive care.

● The manager had completed several audits. For example, a health and safety audit was completed in December 2018, which covered the environment; fixtures and fittings; infection control; staff training and accidents. This audit had identified some shortfalls, such as moving and handling training for staff, although this was still being arranged.

● Other issues identified at this inspection were not picked up in the audit nor was action taken to address them. Under infection control, it stated that the National Institute for Health and Care Excellence (NICE) guidance had been provided to staff, following outbreak of diarrhoea and vomiting. However, we found the service was not clean or hygienic, staff practice was poor and training was required. Sufficient protective equipment, such as aprons, was not always freely available.

● Although regular fire door audits were in place, they had failed to identify several fire doors which did not close properly, posing a risk should there be a fire at the service. Hot water temperatures were also monitored but we found two emersion baths where the water was above that recommended by the Health and Safety Executive.

● Lack of effective oversight meant people were living in an environment which was poorly maintained.

The shortfalls in governance and failure to implement improvements was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff expressed their confidence in the manager and said they were willing to work with her to introduce changes and improvements. A relative said they felt positive about the current manager and felt they were competent to do the job. The manager had a number of good practice ideas in relation to dementia care but had been unable to implement them fully.

● One care worker said they had had a lot of support from the providers and the manager.

● The new manager recognised there were significant areas for improvements and she had developed a service improvement plan. She was trying to rebuild the staff team and planned to appoint a new senior care worker and to develop champions to promote good practice.

Continuous learning and improving care

● Accident and incident were recorded and analysed monthly by the manager. This meant any increase in risk wasn't always picked up immediately as audits were retrospective. The safeguarding investigation found evidence of a person sustaining three falls since the end of January 2019 but the manager was unaware as the monthly audit had not been completed. This meant the arrangements were not always effective. We saw that incident forms had been completed but not always in enough detail to minimise

further incidents.
● Trends from complaints were not used to improve the quality of care and support at the service. We found several of the themes raised as complaints had not been addressed.

The shortfalls in governance and failure to implement improvements was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others
● There was poor partnership working with other services or bodies. For example, the local GP surgery had lost confidence and raised concerns about the service. Concerns related to staff knowledge and skills and the timeliness of some referrals.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Residents' meetings did not take place and people were not invited to give feedback about the overall service they received. The manager and provider explained this was because of the nature of people's conditions.
● The views of people using the service had been sought recently in relation to food following concerns about the quality of meals at the service. Three people had completed surveys, which showed people were happy with the food on offer.
● One person said "I can talk to the manager about anything. Staff are exceptional. Even the boss man (the provider)".
● Two people had completed a survey about staff approach and attitude. Responses ranged from satisfactory to very good.
● A recent relatives' survey had been issued. We reviewed a sample of those returned. Responses were generally positive. However, areas for improvement included the need for more visible staff; cleanliness of people using the service; presence of odours and the lack of activities. The manager planned to collate all responses and develop an action plan to address the suggested improvements.
● Regular monthly staff meetings had been held and were used to up-date staff about any changes, to review procedures, and to enable staff to raise any concerns. These meetings were also used as an opportunity for the manager to discuss various topics, such as safeguarding, falls and promoting people's choice.
● A recent staff survey completed in January 2019 sought their views about the manager's approach; support for staff and whether they were treated equally; whether staff were kept informed and if the manager had people's best interests at heart. The majority of responses were positive, showing most staff had confidence in the manager and found her approachable and fair.

● It is a legal requirement that each service registered with the CQC displays their current rating. The rating awarded at the last inspection and a summary of the report was on display in the entrance.
● The manager and provider were aware of their responsibility to inform us of significant events including significant incidents and safeguarding concerns.