

Cheriton Care Centre Limited

Badbury Care Home

Inspection report

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14 July 2017
17 July 2017
22 August 2017

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Ratings

Overall rating for this service

Inadequate 

Is the service safe?

Inadequate 

Is the service effective?

Requires Improvement 

Is the service caring?

Requires Improvement 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

We undertook an unannounced inspection of Badbury Care and Nursing Home on 13, 14 and 17 July 2017.

The home is registered to provide accommodation and residential care for up to 33 people. At the time of our inspection there were 24 people living at the home, some of whom were living with a diagnosis of dementia. The home is set out over two floors. Access to the first floor is by stairs or passenger lift. The ground floor provides access to a secure garden area.

When the service was last inspected in October 2016 we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. Regulation 12 Safe care and treatment. People's identified risks in relation to skin damage and malnutrition had not been consistently managed or actions taken in order to minimise the risks. Regulation 17. Good governance. Auditing systems had not recognised areas that required improvements to ensure safe care of people. As a result of our findings of the inspection in October 2016 we imposed conditions on the provider's registration in that we required the provider to report to the Care Quality Commission (CQC) about the safety of people's care. Although people and relatives said they felt safe, the risks people faced were not consistently managed. We found examples where people were at risk.

This inspection was brought forward because concerns had been raised by the local authority safeguarding team, health care professionals and a number of safeguarding alerts received by the Care Quality Commission. Regular action plan progress updates had been sent to the Care Quality Commission following the last inspection. Information we received did not reflect the concerns and risks found during this inspection. At this inspection we found concerns about the safe care and treatment for people living at the home, consistent with concerns raised prior to the inspection taking place.

We found there was a lack of consistent and effective management and leadership which coupled with ineffective quality assurance systems meant issues were not identified or resolved. This was evidenced by the continued breaches we found at this inspection. We identified five breaches in regulations, staffing, safe care and treatment, safeguarding, person centred care, and good governance. Two of these were repeat breaches over the previous two inspections.

People's identified risks in relation to skin damage had not been consistently managed or actions taken in order to minimise the risks. Some people needed to be supported by staff to change position regularly in order to relieve pressure on their skin. Clear instructions were recorded in care plans. However these instructions were not always being followed.

People were at risk of malnutrition. Food and fluid records were kept in people's rooms. They were vague and did not reflect how much people had actually eaten or drank, yet there were clear instruction in records for staff to ensure people ate and drank well.

Systems were not in place to ensure people received their medicines safely. Stocks were not always available to ensure people received their medicines when required.

The requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) were not being met as we found conditions which had been applied to DoLS authorisations had not been complied with. Quality monitoring and audits had failed to identify that areas of service provision were not meeting the requirements of the law.

When other health care professionals had given the provider specific instructions on how to care and support people these were not consistently followed putting people at risk of unsafe or inappropriate care.

People and their relatives knew how to raise a concern or make a complaint. There were systems in place for people, staff and visiting professionals to give their feedback on the service. Staff felt able to approach their managers and raise any concerns.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are considering the action we are taking and will produce a further report.

The overall rating for this service is 'Inadequate' and the service therefore in 'special measures'. The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. 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.

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?

Inadequate ●

The service was not safe

The deployment of staff meant people's emotional and social needs were not met in a timely manner.

Systems for the management of medicines were unsafe and did not protect people using the service or ensure they received their medicines as prescribed.

Risk to people's care and wellbeing was not being consistently addressed and did not identify specific risks and the measures which needed to be in place to keep people safe

People were supported by staff who knew how to identify and report abuse.

Is the service effective?

Requires Improvement ●

The service was not effective

People were not always supported with appropriate nutrition and hydration.

People's rights were not fully protected because the principles of the Mental Capacity Act 2005 were not always being followed.

Where people had conditions relating to the Deprivation of Liberty Safeguards we could not be sure the conditions had been acted upon.

People were not protected from the risk of unsafe or inappropriate care because staff did not have the knowledge and skills to safely and effectively deliver the care people needed.

Is the service caring?

Requires Improvement ●

The service was not always caring

People were not always supported in a way which promoted their dignity.

People were not consistently being supported in line with their preferences

Staff were kind, caring and compassionate towards people who lived at the service.

Is the service responsive?

The service was not responsive

People did not receive care and support that was responsive to their changing needs.

People did not always have access to a range of activities meaningful to them.

There was a system in place to manage complaints. People told us they knew how to raise any concerns or complaints.

Requires Improvement ●

Is the service well-led?

The service was not well led

Whilst there were auditing processes in place, these were not effective in identifying concerns and ensuring these were resolved in a timely manner.

Records were not always completed in a timely manner and there were errors and omissions in key records for example risk assessments and medicine records.

People and staff had access to their management team and felt able to approach their managers.

Inadequate ●

Badbury Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 13, 14 and 17 July 2017, and was carried out by two adult social care inspectors, a pharmacist inspector and a specialist advisor who was a nurse. On 22 August one adult social care inspector returned to the service to gather additional information.

Before the inspection we reviewed information we had received about the service including notifications. Notifications are information about specific important events the service is legally required to send to us. We also considered information shared with us by the local authority safeguarding team relating to a number of concerns they were in the process of investigating.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also considered the information supplied by the provider required by us as part of a condition of their registration.

During the inspection we spoke with, 12 people and five relatives about their views on the quality of the care and support being provided. We also spoke with the registered manager, the operational manager, operational director, quality manager, deputy manager, and six care workers. We spoke with five health professionals, before and after the inspection. We looked at documentation relating to six people who used the service, eight recruitment files and training records and records relating to the management of the service, and 24 records relating to the management of medicines.

Is the service safe?

Our findings

At the last inspection in October 2016, We found the risks people faced were not always managed sufficiently to ensure people's safety. In response to this we used our enforcement powers to impose conditions to the provider's registration which required them to report to CQC about the safety of people's care. Before this inspection we received significant information of concern about the safety of people living in the home. During this inspection people remained unsafe as risks relating to their safe care and treatment were not managed appropriately.

People did not always have their prescribed pain medicines available. This placed them at risk of pain. Medicines were not available to be administered because stock levels had not been maintained. Three people's records showed they were receiving additional medicines for pain relief. Records showed these medicines had not been ordered in sufficient time to allow delivery before the existing medicines ran out. The provider had not followed up on the delivery of these medicines. Staff had recorded that people had refused their medicines when there were in fact no medicines to give. We asked the registered manager why the systems in place for recording and ordering medicines had failed. The registered manager was unable to give an explanation, but explained, that the pharmacy had failed to deliver, and they were looking at changes to their systems.

The provider was dispensing medicines covertly to two people. (This meant people were having their medicines administered in a disguised form such that the person would not know that they were taking them). For most people appropriate safeguards were in place for this to happen. However, one person was receiving their medicine covertly who the registered manager told us had capacity to refuse this medicine. We later discovered that the person had been previously assessed as lacking capacity to consent to this medicine. The correct procedures had not been followed and we advised the provider to seek guidance and support in regards this person's right to refuse to take their medicines. The registered manager took immediate action to review the practice during the inspection.

Medicines were stored safely. However we observed a number of medicines, where the manufacturer specified a reduced expiry date when opened, that did not have the opening date recorded. This meant that the provider could not ensure that these medicines were safe and effective to administer. We raised our concerns about the administration of medicines with the registered manager who informed us all staff who administered medicines had received the appropriate training. Following the inspection the provider informed us, "Additional competency assessments were taking place for all staff administering medicines".

Where people were prescribed creams and ointments, staff either did not apply the creams or they did not record when they had applied the creams. For example one person's care records showed the person had been prescribed four different creams which needed to be applied twice daily. We observed the person's records over one week period. The record stated the person had not been offered the cream on 12 occasions. It was not clear if people were receiving the creams as prescribed by their GP, or records had not been completed correctly. We found concerns with three people whose risk were not well managed and they developed new pressure sores. For example a visiting GP found a new pressure sore on the person's

sacrum. Staff did not record this new information in their daily notes. This meant people remained at risk as staff were not recording when people's health needs changed.

Where people needed support with repositioning, charts were in place in rooms. Charts showed the times people needed to be repositioned. Charts were not always completed in respect of guidelines. For example, one person's chart showed they need to be repositioned every two hours. Records showed on 12 June 2017 the person had no recorded entry of their position being changed over a 12 hour period. There were inconsistencies with the timings throughout the two week period of records we reviewed which showed the person had not been supported at the assessed times.

People were not always supported to meet their assessed needs in a timely way. One person's health professional records detailed how they should be supported to prevent pain and skin damage. We observed that this person was not positioned in accordance with the advice from the health professional. A care worker informed us they were unaware of the correct position this person should be supported to achieve and told us, they were "Unsure what contractures they had if any".

Some people were assessed as being at risk of constipation. The registered manager told us that they encouraged staff to record all bowel actions in the daily record of care. Care plans directed staff to link to 'continence records' for recording of bowel movements. We checked eight care records for people who could be at risk of constipation due to poor fluid and food intake, and there were no recording of bowel actions over a period of one week. Three of the people's records we looked at had a diagnosis of dementia. Daily records identified where people had been supported with personal care, however there were no guidance for following up with concerns or how risks should be managed in regards constipation. One person had needed to receive medical intervention for faecal impaction. Another person's daily records recorded blood had been found in the person stools. The GP had asked for this to be monitored, however there was only one further reference to a bowel movement, and no indication this was being monitored. This meant people were at risk of not receiving appropriate support and intervention in regards their health and well being when required.

People's risk of skin damage was not managed safely. One person's care records identified they should not sit in the chair for more than 90 minutes at a time as it put them at high risk of skin damage and pain. Staff confirmed they were aware the person should not be sat in their chair for long periods of time however, one member of staff told us that they could not always support the person to change position as they were "too busy". There was no guidance to staff on how to support this person to change position or system to monitor when the person had changed position. The registered manager was unable to give an explanation as to why the repositioning support had not taken place, or why the person had not been supported in line with their identified care needs.

This is a repeat of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

The registered manager told us they always had sufficient staff on duty. They informed us they used a dependency tool to determine the amount of staff required on each shift. They informed us they aimed to have one senior care worker and five care workers between the hours of 7.45am and 8pm. At night the service was covered by one senior care worker and two care workers. Rotas reflected the numbers of staff needed. However the service had a high turnover of staff. The management team were aware of the issues this raised and were working to recruit new staff. They informed us, regular agency staff were used to support the staffing levels at the service whilst new staff were recruited.

People considered there was not enough staff to support them in a timely manner. One person told us, "They can't cope, I can't operate the lift to go downstairs, and they say they will come back in two minutes. It normally half an hour or more". Another person told us, "The problem here is there are a lot of people who need more attention, so I have to wait". A third person said, "I have had three or four falls in the last month, they are very good when they get to you".

Staff considered there were not enough staff to support people. One member of staff told us, "It is stressful, there have been lots of changes with staff leaving. There is no management support, they just put the pressure back on us and don't listen, and tell us the staffing levels are correct". Another member of staff told us, "We are stretched. We don't have time to just sit and have a chat with anyone." One member of staff told us, "Sometimes we take risks, if there are not enough staff to do the double up we do it ourselves". The registered manager told us they were confident their staffing levels were correct.

Relatives raised concerns about staffing levels. One relative told us, "Sometimes at weekends there are only three staff on duty, I think there should be more". Another relative told us, "It is difficult to get in at weekends. Staff have to let us in and at weekends there is nobody in the office. You have to wait until a staff member becomes free. There are often only three member of staff on duty at the weekend". A third relative told us, "I come in at different times through the week, but at least twice a week they seem very short staffed." They further commented regarding their concerns about another person using the services who their relative was scared and worried about as they had repeatedly entered their room and had pulled them from their chair. They went on to tell us, "It worried [relative's title] so much she can't settle at night as it also happened at night. I have heard it happens to other people here".

We observed staff were not deployed in a way that enabled them to meet people's needs in a timely manner. For example, staff were seen to be task focused, when they took drinks into a person's room they came straight out. People sat in communal areas or in their rooms with minimal staff support or interactions. Call bells were heard to ring for prolonged periods. When we asked the registered manager for their call bell audit, they informed us, "Currently the system was unable to complete audits". They were hoping this issue would soon be resolved. When emergency call bells rang a number of staff ran to answer it.

We looked at daily records which evidenced how the staffing arrangements had impacted on people's wellbeing. Which confirmed staff were unable to meet people needs in a timely manner. For example. An entry in a daily record on June 2017 stated, "[person's name] is confused. Urine sample taken, however not enough staff to send the sample". This meant people were at risk of not having their health needs met in a timely manner.

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

The provider had a system in place for checking the suitability of new staff to work with vulnerable people. Before commencing work all new staff were thoroughly checked to make sure they were suitable to work at the home. These checks included seeking references from previous employers and carrying out disclosure and barring service (DBS) checks. The DBS checks people's criminal record history and their suitability to work with vulnerable people. Staff told us they had not been able to begin work in the home until all checks had been completed and records seen confirmed this.

Staff had policies and procedures to report safeguarding issues. This procedure provided staff with the contact details they could report any suspected abuse to. The policies and procedures we looked at told

staff about the types of abuse, how to report abuse and what to do to keep people safe. Staff members confirmed they had received safeguarding training and knew how to identify and report abuse.

Regular assessments of the environment people lived in were conducted to ensure that people were safe. Regular servicing of equipment such as hoists, walking aids, gas installations, fire safety and prevention equipment were carried out. We observed staff supporting people with moving around the home. The equipment they used to do so was used safely. People had individualised personal emergency evacuation plans (PEEP) in place that enabled staff to ensure, in an emergency, they were able to evacuate people in a safe and timely manner. These had been reviewed to ensure they reflected people's current needs. Staff were able to demonstrate the action required to support people in emergency situations.

Systems were in place to support people to live in a clean environment. Cleaning schedules were in place and housekeeping staff were seen to be cleaning around the home. Domestic staff were able to demonstrate what action to take if there were any concerns with infection control. For example when one person had recently had an infection the staff told us how they had put control measures in place which stopped the infection spreading to other areas of the home. There were sufficient supplies of personal protective equipment (PPE) for staff located around the premises.

Is the service effective?

Our findings

People's legal and human rights were not fully protected because the principles of the Mental Capacity Act 2005 (MCA) were not being applied appropriately. 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.

Whilst assessments of people's capacity had been completed for wide ranging topics, they were not completed in line with the principles of the MCA codes of practice. For example, one person told us they did not wish to remain at the home. They had signed their consent to stay in the home for a short period of respite which had now passed. The person was distressed at their situation of remaining in care. The provider had not held a discussion with the person about their right to leave, although an advocate had been asked to visit the person by a professional involved in supporting the person. The registered manager told us they would review the situation. Following the inspection the registered manager informed us discussions were now taking place with the person. We also raised a safeguarding alert to the local authority in relation to this issue.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Conditions attached to authorisations to deprive people of their liberty were not always met which meant their human rights were not always protected. A person was subject to a DoLS authorisation with conditions. The conditions stated the person "Must be afforded the opportunity to take part in social activities and to participate in gardening". The staff were unaware of these conditions. Records from January 2017 reflected that the person had not been supported into the garden or participated in any form of gardening. The registered manager had not realised that this person's DoLS was current. The provider told us that they had taken action to ensure the conditions of this person's DoLS authorisation were met from 20 July 2017

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safeguarding

People's nutritional needs were assessed to provide a diet in line with their needs. A number of people using the service were prescribed 'Thickeners' to assist them in swallowing liquids safely. We observed one care worker mixing a person's drink, they were unable to tell us the consistency they were looking to achieve, nor did they know how much thickener to use to create the required consistency. This put the person at risk as they were not drinking fluids at the safe consistency as outlined on their safe swallow plan written by a Speech And Language Therapist (SALT). Other people were observed to be supported in line with their safe swallow plans and staff were able to demonstrate awareness of people's risks. One health professional told

us "The staff are very caring but seem to lack the skills needed to understand people's needs".

People's nutritional needs were not effectively met, people were not having enough to eat and drink. Records were inconsistently completed or professional recommendation not followed. For example. One person's recommended daily input was 897 ml of fluid. The recordings for 3 June 2017 showed the person had 250ml of fluid. In the person's daily records staff had record the person had "An ok diet and there were no concerns for the day". A visiting GP informed us they had requested to see three weeks charts for fluid and food intake as they remained concerned the person was still low in weight and instructions were being followed, due to staff lack of understanding of the importance of following instructions in regards the importance of recording and monitoring intake. They informed us records had not been located. This meant people were at risk of dehydration and malnutrition.

The system in place for people to have a choice at mealtime or have their dietary needs met was not effective. For example one person records showed following assessment they now required a fortified diet due to increased weight loss, the chef was unaware of this new information as information held in the kitchen was not up to date. Although the chef was able to tell us about people's dietary needs such as diabetic needs, they were not aware of all people likes and preferences. The chef only held information on 17 people out of 24 living at the home. The information the chef held included where people liked to eat their meals and their preferences in regards their likes and dislikes. This meant the chef did not have full information for seven people which meant there was a risk people's choices were not being met.

People who were identified as nutritionally at risk were having their foods fortified (such as full fat cream, full fat milk, or full fat cheese added to their meals) to help increase their weight and their food intake was monitored. The chef informed us, "All food that can be fortified is fortified". This meant people were at risk of receiving food of the wrong consistency and gaining additional weight even if they did not need to. One person told us, "My family can't believe how much weight I have put on since moving here". Another person told us, "I have gained some weight since I moved here, not sure I needed to".

People told us they received support from other health professionals but did not have access to a dentist. One person told us, "I have lost my bottom teeth so just have to have soft food now as I can't chew. Must admit I get fed up with omelettes". Another person told us. "I don't get to see the dentist anymore". Another person who was receiving personal care in bed, care records stated 'To brush teeth twice a day'. There were no records that indicated this support was being given. The person's mouth looked very dry. We discussed this with the registered manager who told us they no longer have the support of the 'Flying dentist' but would address the issue to ensure people had access to a dentist. This meant that despite the registered manager being aware that dental support had been stopped no further action had been taken to find alternative arrangements for meeting people's dental needs.

There were no specific diabetes care plans in place for people to include foot and eye care and dietary needs, however people had regular access to health professionals for diabetic support . Although staff told us and records showed staff had received on going training and development, not all staff had the skills to support individual needs such as diabetes. Care records held information informing carers what to do if a person's sugar levels dropped. One record referred to blood sugar below 4 and action to take if people's sugar levels dropped. Care workers told us they had not been trained to undertake this practice of checking people's sugar levels, this was left for district nurses, but they "Did have a box of sweet treats" if people felt unwell. This meant people were at risk of not receiving appropriate and immediate response should their blood sugar levels become dangerous to their wellbeing by staff who had the skills and knowledge to support them. One health professional told us, "I am not sure the staff have the relevant skills and knowledge to understand some of the complex care needs of people they are supporting".

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

By the end of the inspection the local authority were satisfied that the immediate safety concerns had been reduced. The home was being supported through an improvement forum to ensure improvements were sustained.

We observed lunch in the dining room, tables were nicely set up with table cloths, napkins and fresh flowers on the tables. Jugs of juice and snacks were available throughout the day. There was a small menu on the side in the dining room which was easily missed. People told us they had not seen the menu. We pointed it out to one person who said they "Had not noticed it before". On the final day of the inspection the provider had made improvement to the dining area, including larger laminated menus with a full colour picture menu on each table ensuring people were aware of their choices throughout the day.

Most people told us they liked the food, although one person told us they felt soft food choices were limited and another person said they found the lamb tough. People we spoke with told us they did not know what they would have for their dinner until it came to the dining room. Staff told us people were offered choice in the mornings but sometimes forgot what they had requested. This meant people were not offered the opportunity of making decisions about their meals before food was brought to the dining room. We suggested to the registered manager people living with dementia may need more visual prompt regarding their food choices.

Staff told us they received an induction when they started working at the home. The induction programme was linked to the Care Certificate. The Care Certificate standards are recognised nationally to ensure staff have the skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. One care worker told us, "I had a three week induction, now I am shadowing more senior staff" The induction included a period of 'shadowing' experienced staff. Staff comments about the induction included, "My induction was very good and I felt supported to do my job". "I went to Portland to do my induction it was good, I shadowed senior staff then".

Staff told us they received refresher training to keep their skills and knowledge up to date. The training provided was evidenced by the provider's staff training matrix and staff induction checklists.

Staff received supervision, however the registered manager told us staff had not received annual appraisal but were hopeful with the appointment of the deputy, supervisions and appraisals would become more regular. Supervisions were an opportunity for staff to spend time with a more senior member of staff to discuss their work and highlight any training or development needs. They were also a chance for any poor practice or concerns to be addressed in a confidential manner. When asked staff said they had received supervision.

The building was set out on two floors, the rooms were spacious to allow the use of specialist equipment and corridors were wide enough to allow people to be moved easily in wheelchairs. A lift was available to allow people to move freely on both floors.

The accommodation and grounds were maintained to a high standard and provided a pleasant environment. However they had not been adapted to meet people's dementia needs People's bedroom doors were painted different colours and looked like front doors, although bedroom doors were individually numbered, there were no other guides for people, such as memory boxes or sensory and remembrance areas. Some toilets had no signs on the doors informing people who may be confused these were the toilet

facilities. One person was seen to be confused going from room to room. Staff were heard to guide the person back to their room.

Is the service caring?

Our findings

People told us they were supported by kind and patient staff. Staff were busy throughout the inspection supporting people with personal care, supporting people to eat and drink. This impacted on staff ability to respond and spend social time with people. Staff told us they would like to spend more time talking to people, but there was little opportunity to do so. One person told us, "The staff are always very kind and caring, they are just very busy".

People and their relatives told us the staff were kind and caring and treated them with respect. Although staff were busy most of them displayed a friendly, kind and caring approach toward people in the home." One person said, "Of course staff are kind why wouldn't they be". A relative told us, "Staff are nice but you can see they are struggling, so many have left recently". Another person told us, "This is a nice place to live if you have to live in a home." A third person told us, "Carers are so patient, the lady next door keeps ringing her bell, they never tell her off". However our observations did not support what we were told.

Staff were task focused. People had their physical needs, such as washing and dressing met, this took up the majority of staff time meaning that once people had received personal care there was very limited interaction with staff until they required another task to be performed." One person told us, "Staff used to take me out for a walk, I enjoyed that but they don't do it anymore. They don't have time". This meant people were not always being supported to pursue interests that were important to them.

Some people who were frail and unable to leave their beds had their personal items and photos on shelf's out of sight. We showed one person one of their photos when they asked us about the war. The person asked for their photo to be placed on a shelf in front of them. The following day we noted the photo had been moved behind the person's bed again. We discussed the person's wishes with staff, who told us they would put the photo back. We did not see the photo put back for the person. Another person told us, "There are no clocks around or calendars which show what the date is. It would be nice as all the days seem the same".

Care plans described people's individual communication needs, decision making capabilities and things they enjoyed or disliked, however these were not always correct.

Some staff were unaware of people's past history or personal likes and dislikes. For example, one person told us they were called by a name they did not wish to be known by since moving to the service. We passed this information on to the management team. The person had been called the same name prior to moving to the home. They told the registered manager they wished to be called a different name. We observed throughout the inspection the person was still not referred to by their preferred name. We heard one member of staff call the person by the wrong name and reminded them. They told us, "Oh that will be hard as we know them by a different name". The person told us they understood it would be difficult for staff to remember the name they wished to be called by. However they told us, "It is important to me it is my name."

We observed most of the staff displayed a caring approach, and knew people well. However when we asked staff individual questions about people's individual interests written in the care plans they were unsure of individual interests or past history. For example, we asked four staff members about a person who had a particular interest, which was recorded in their care plan. The staff were unable to tell us what the person's interest was or what their previous employment had been. Another person's care records identified the person should be encouraged to wear glasses at all times. The person was seen on each day of the inspection not wearing them. There were no recordings in daily records that the person had been offered their glasses and had declined to wear them. This meant people's individual needs were not being adequately managed.

People were supported by staff who showed little insight into people's social and emotional needs. One person told us, "I was going to sit in the garden but staff don't have the time to take me out". Another person told us, "They [staff] bring our mail to the dining room when we are eating lunch. I don't like that. Today the mail has been brought to my room. My mail is private and I would like to open it in privacy". Another person told us they did not like sitting next to the same person every day, they said, "I don't really like [person's name], every time I try to talk to someone they butt in". The person added they were anxious they may get left in the lounge at meal times and had to rely on the same person to use the call bell to call for staff. They told us this had happened before.

On each day of the inspection we observed there were periods of times when no staff were present in communal areas where people were sat. There were two communal lounges, and smaller seating areas on both floors. One person said, "They [person's name] always have the remote control." The television was playing very loudly on each day of the inspection and would have prevented people from holding conversations. We asked staff why televisions were so loud they informed us, "People are hard of hearing so like them loud". On the final day of the inspection staff were seen sitting with people in the lounge areas, people had moved chairs and the remote control was being shared. The television volume had been turned down and subtitles added to the tv. One person told us ,they were much happier now they had moved seats. The provider has two separate lounges on the ground floor. There is also a dining and lounge room, sofa seating in an entrance area and upstairs spaces for sitting and talking more intimately if needed.

One lounge was used by the independent activity coordinator, who promoted singing, quizzes, and reading to people. People told us they really liked the time they spent with the independent activity coordinator and, "Looked forward to her visits.

Staff always knocked on doors and waited for a response before entering. We noted that staff never spoke about a person in front of other people at the home which showed they were aware of issues of confidentiality.

Is the service responsive?

Our findings

At the last inspection in October 2016 we found people did receive responsive care and support. At this inspection we found people did not always receive care that was responsive to all of their needs because care plans were not accurate or followed.

People's care plans detailed the support required however we found staff did not always follow the guidance. For example one person had been assessed as 'needing additional support with exercises'. The exercises were important to them as they needed to achieve their goal of returning home. The person told us, "The physio said I need to do these exercises. I need the staff to help me". There were mixed comments from staff why the exercises had not been taking place. Some staff told us, they did not know about them. One care worker told us, "[person's name] need to build the strength up in their arms first". This instruction was not stated in the person's care records. The registered manager could not provide an explanation as to why the person was not being supported in line with the professional instructions given.

Care plans were reviewed monthly, most comments read "Information still relevant". However we found this was not the case. One person's care plan relating to personal care detailed how staff should support them in a way that reduced the chance of them becoming aggressive due to their dementia. This support was also used to reduce the chance of aggression when staff supported the person with continence care and eating and drinking. The support had not been referenced in the care plan which meant the person was at risk of receiving inappropriate and unsafe care if supported by staff who did not know them well. Another person's care records held personal information from another person from a different home. The registered manager could not explain how the information was in the wrong care plan and the wrong home. A third care plan directed staff to ensure a wheelchair assessment was completed. The assessment was completed on 2 June 2017. The request was to ensure the person could be taken out of the home, "At least once a week with a goal to build up to more trips out or to be able to sit in the garden". The person had not been supported outside of the home although had the wheelchair in place to support the activity.

Whilst there was a system in place to review people's care records there was little evidence that people had been consulted as part of the reviews. The people we spoke with told us they had not been involved in the reviews of their care plan. One person said "I don't see a care plan, but staff seem to know what we want". A person's care records detailed that they had spoken with staff about not wanting to be disturbed at night. This had not led to a review of how their care was provided and staff reported that they had explained to the person why they did this. Following the inspection, records were shown to the inspection team where people had been questioned with regards the care and support they wished to receive.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care.

On the first day of the inspection a residents and family meeting was held, in regards concerns which were being raised about the care and welfare of people living at the service. People and their relatives were informed each person would have a review of their care. One relative told us they had already spoken with a

social worker who had rang them about concerns in regards the service. People were able contribute to the meeting. People told us they had been informed of the meeting, some had declined to go. One person told us, "I didn't want to go but I asked the person who was running the meeting to come and see me, they never came". The first meeting was attended by five relatives and four people.

There was an activity programme and newsletter in place. The newsletter gave information of activities or events that had taken place and forthcoming events. There was a weekly activities programme on display in the dining room. However there were no activity coordinators employed at the home. Although some people were seen to be supported into the dining area to take part in the musical session, many remained in their rooms. One person told us, "I found some musical entertainment by accident". The person's care plan stated they were at risk of isolation. We heard the person on a number of occasions asking staff for support to use the lift to go downstairs. We noted the support was not always immediate with the person being informed they will be back.

On two of the days of the inspection there was musical entertainment offered however it was noted there was little stimulation for people who remained in their rooms. One person told us, "There is nothing to do". Whilst some people had interaction downstairs with an independent activity worker the majority of people had very little social interactions. Staff said whilst they did talk with people during tasks they were unable to give them any extra time. The registered manager told us a new activity coordinator had been employed to start work in August 2017 in the meantime, activities would continue with outside entertainers and the independent activity coordinator. This meant people who were unable to attend the activities outside their rooms remained at risk of social isolation. On the final day of the inspection on 22 August 2017, the activity coordinator had began working at the home. A record was being kept of support being offered to people who were in their rooms reducing the risk of social isolation.

The complaints policy was displayed in the home. We found two complaints had been received since the last inspection and records we reviewed showed these had been investigated and the outcome had been communicated to the complainant. Relatives said if they had any concerns or queries they told staff and they were dealt with efficiently. The registered manager told us there was an open door policy in the home, and anyone was welcome to speak with them at any time. They told us they welcomed both complaints and compliments and looked upon them as, "A way to learn".

Is the service well-led?

Our findings

At the last inspection in October 2016 and the previous inspection in September 2015, we rated this key question as requires improvement. In response to this, we imposed a condition on the provider's registration in that we required the provider to report to the Care Quality Commission (CQC) about the safety of people's care and how this was being monitored. The provider sent us action plan stating the action they would take to address issues and improve the quality and safety of the service. We found continued regulatory breaches which demonstrate the quality and safety of the service had not improved. We found those risks remained at this inspection meaning that the governance systems at the home continued to fail to protect vulnerable people.

Systems in place to assess, monitor, manage and mitigate risk were not effective. This meant people were at risk of receiving unsafe care and treatment. People's identified risks in relation to skin damage had not been consistently managed or actions taken in order to minimise risks. Assessments had not been reviewed regularly and when referrals had been made to health practitioners their instruction had not always been followed. The providers auditing of these areas had not identified any concerns and as such the risks to people's health and safety was not being effectively managed.

The provider did not have effective quality assurances systems to ensure people received appropriate, safe and good quality care. During the inspection we found inappropriate care practices in regards of monitoring of people's individual needs. Poor recordings in respect of people's fluid intake and hydration needs. Care plan reviews did not always identify impact of health needs, or actions taken to improve well-being. Daily records did not identify what activities or stimulation people were offered. All of these issues had not been identified through the provider's monitoring systems.

The provider wrote to the Care Quality Commission on 27 June 2017, confirming an audit had taken place which had covered areas such as nutrition and hydration, tissues viability record keeping. Although the provider stated effective monitoring systems were in place, we found the quality audits undertaken by the provider had not been effective in reducing risk to people wellbeing and safety. This meant the systems had been ineffective in ensuring improvements had been made because we found similar concerns during our inspection. Other statutory agencies had been concerned about the quality of care and safety of people using the service. The provider had been addressing a number of different demands focussed on improving standards within the home.

As part of the governance arrangements, the provider had monthly audits which set out areas expected to be monitored by the senior management team. For example, complaints, pressure ulcer incidents, review of previous month's action plan, review of reports from other agency's such the fire department and environmental health. In addition, staffing issues such as supervisions, sickness and absences formed part of this policy. As well as menus, hygiene, cleaning records and maintenance issues. The registered manager showed us a list of audits they completed which were in line with the policy and were one of the methods they used to monitor the quality of care. However when we discussed some of our concerns in regards the monitoring of the audits the registered manager informed us, "Their systems had not always been robust".

We found that audits continued to be ineffective. 20 people's care plans had been audited as part of work undertaken since our last inspection. These audits had not identified concerns about people's care identified at this inspection.

Following the inspection the registered manager informed us, they planned to undertake all monthly audits alongside the new deputy manager to ensure there were robust systems in place in regards reviewing systems. The systems in place to ensure people received safe care and treatment were not effective.

Although systems were in place to support people who required regular repositioning, records showed there were inconsistencies in the support provided. People's identified risks in relation to skin damage and malnutrition had not been consistently managed or actions taken in order to minimise the risks. Assessments had not been reviewed regularly and when referrals had been made to health practitioners these had not been followed up. One health professional told us, "We have been working closely with the service to try to improve practices it seems nobody in here is in charge. There seems to be no sense of urgency or systematic approach or guidance for staff".

Quality assurance processes had not been successful in recognising that fluid charts showed some people were not drinking for long periods at times. People's prescribed creams were still not being applied in line with the prescriber's instructions. These people were at risk of, or already had skin breakdowns and the lack of regular application of their creams meant they had not received consistent benefit from them. Records of regular checks on people to keep them safe by repositioning were inconsistent. Health professionals raised concerns in regard the registered manager and operations manager understanding of interventions.

Systems to monitor people's care records to check that information was up to date and accurate were ineffective. For example, we overheard a member of the management team informing a GP surgery over the telephone a person did not have a pressure sore. The records for this person had been incorrectly completed following a district nurses visit. The operation manager had checked the daily record, but had failed to collaborate the information with staff on duty, before giving feedback to the doctor. A member of the inspection team, who had heard the feedback from the district nurse, informed the management member they were giving the wrong information. They immediately retracted their mistake.

There had been insufficient management oversight to ensure that all the issues we had previously reported on had been properly resolved. Systems had not picked up that people's rights were not being protected We reviewed eight people's care records which showed that they did not reflect what we had been told by the care staff about people's care records and about people's changing needs. Where areas for improvement had already been identified, appropriate changes had not been made without delay to address these. The lack of robust auditing meant that the service had no effective systems in place to continually monitor the service provided to ensure people information remained relevant and people received safe and effective care.

New concerns also emerged at this inspection. Systems for ensuring that people were supported to have their human rights upheld. People's rights were not fully protected because the principles of the Mental Capacity Act 2005 were not always being followed. Decisions were being made for people where they had capacity to do this themselves. Conditions which had been applied to DoLS authorisations had not been complied with and mental capacity assessments were not always clear. Following the inspection the provider informed us action had been taken to ensure people were being given the appropriate independent support to make decisions. Where people lacked capacity, best interest decision making process were in place.

Systems were not in place to ensure people received their medicines safely. Stocks were not always available to ensure people received their medicines when required. A number of medicines where the manufacturer specified a reduced expiry date when opened that did not have the opening date recorded. This means that the provider could not provide assurance that these medicines were safe and effective to administer. These issues had not been picked up in the provider's audit.

Accidents and incidents had not been effectively monitored or reviewed by the provider. An example was one person had three accidents within three days. One incident recorded the person had fallen from their chair, as the chair had not been set in the correct position, another recorded the person foot had been hurt as their foot rest on their wheelchair had not been used, and the third said the person had been hit in the eye by a bed rail. The monthly accident and audit sheet had been ticked as reviewed. We discussed this with the registered manager who was unaware of the issues. They told us, "We have a tick chart system with regard auditing, which I had off loaded onto different senior staff. I believe this has caused some of our current issues".

This is a repeat breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance

The registered manager told us they were aware there were concerns within the service and had been addressing these concerns and keeping people and their relatives informed of the actions they planned to take to improve the service. The registered manager told us, "I complete a daily walk around, improvements are on-going. Our quality audits will now be completed on computers and sent to our head office. There have been a lot of staff leaving, which has made it difficult". However staff spoken with felt the registered manager was approachable. People spoke about the registered manager by their first name. One person said, "Trouble is he is too nice." Staff felt able to approach their managers and raise any concerns.

The registered manager was supported by an operation manager and operations director. They told us they held monthly audits with senior managers. The operation manager told us they had been located at the home on a full time basis over the past four week, offering additional support to the registered manager. This support had not increased the accuracy or validity of the homes auditing system. The registered manager had been managing another of the provider's home. They informed us they would only be managing Badbury. They told us, "It will be much easier, I will be able to concentrate and get Badbury running effectively, I plan to take the home to an outstanding rating." On the final day of the inspection, changes had been made to the management structure of the home. A new operation manager was in post to oversee additional training and development. The residential manager was being supported by the provider to focus solely on improvements in Badbury.

We looked at minutes from the most recent staff meeting held on 15 February 2017 discussions had taken place relating to recruitment, safeguarding and complaints, activities, newsletter and CQC inspection. The registered manager advised staff the action plan had been submitted to CQC following the last inspection and report. This meant staff were kept informed and were able to contribute to changes.

The registered manager had systems in place to ensure the building and equipment were safely maintained. The utilities were checked regularly to ensure they were safe. Essential checks such as that of fire safety equipment, gas, hot water temperatures, took place.