Belmont Sandbanks Limited

Madeira Lodge Care Home

Inspection report

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21 October 2022

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Madeira Lodge Care Home is registered to provide personal care and accommodation for 48 older people, people who live with dementia and people who need support to maintain their mental health. At this inspection there were 48 people living in the service.

People's experience of using this service and what we found
People were not protected from harm. We found people had been locked in their bedrooms during the night without their consent and without appropriate legal authorisation. . People did not have full, detailed risk assessments and care plans to enable staff to care for people appropriately. Staff did not follow safe practices when supporting people who needed help to move.

There were significant concerns with the records completed at Madeira Lodge Care home. Care plans lacked detail and had not been regularly reviewed. Some were held on paper records, others on the electronic care planning system, some held on both but did not show the same information. Audits and checks had been completed but were not effective in identifying issues.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. Mental capacity assessments were not completed properly and were not individual to the person being assessed to make the decision.

We had significant concerns regarding the culture of the service. Concerns had not been raised by staff to the management team about poor practice in the service. The registered manager told us they noticed a change in the atmosphere amongst the staff since actions were taken following our unannounced visit but did not recognise the wider culture of poor practice in the service.

Staff were not deployed effectively to meet people's needs. There were many people who were independently mobile and living with advanced dementia who walked around the service without support or interaction from staff. Staffing numbers were determined by the providers dependency tool, which calculated the numbers of staff required to safely meet people's needs. However, this was not reliable or accurate as people's needs had not been reviewed regularly to determine if the dependency was still relevant.

Accidents and incidents were recorded, but records lacked details of what action was taken, by who or what was needed to reduce the risk of reoccurrence.

Staff did not have the skills or experience to meet the needs of people who were living with advanced dementia.

The dining experience we observed was not positive. Although people were given a choice of food, there was a lack of staff input to make this a pleasurable experience.

People were not always supported to access healthcare in a timely way. Although we found records of people having follow up review appointments with professionals involved in their care, instructions from professionals were not always followed.

Staff did not always treat people in a caring, personal and dignified way. Language used by staff was not kind and interactions we observed did not always treat people well. Staff appeared to lack skills to manage situations where people were becoming distressed or anxious. There was a lack of resources to ensure all people had the chance to engage in activities to help them interact and socialise. There was one wellbeing coordinator responsible for activities for all people in Madeira Lodge Care Home. People did not always have their social needs met.

Staff were recruited safely and demonstrated good infection prevention and control practice.

The layout of the service was large and spacious and there were a number of communal areas for people to choose to spend their time.

The provider and registered manager had a system in place to appropriately record and investigate complaints which had been raised. The registered manager understood their regulatory requirements to inform the Care Quality Commission (CQC) of significant things which had happened at the service and had completed this.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was good (published 04 June 2021)

Why we inspected
We undertook a targeted inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about safety of people, staffing levels and risk assessment and care planning. A decision was made for us to inspect and examine those risks.

We inspected and found there was a concern with the safety of people using the service, governance, mental capacity assessments, DoLS and care plans so we widened the scope of the inspection to become a comprehensive inspection which included the key questions of safe, effective, caring, responsive and well-led.

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

We have identified breaches in relation to people's safety, abuse, person centred care, safeguarding, mental capacity, record keeping, effective checks, audits and staffing at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is

added to reports after any representations and appeals have been concluded.

Follow up

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

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

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

The provider applied to remove this location from their registration in order to register it under a new company. This was completed following this inspection. We will use the findings from this inspection to inform the regulation of the new provider for Madeira Lodge

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below	**Inadequate**
Is the service caring? The service was not caring. Details are in our caring findings below	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below	**Inadequate**

Madeira Lodge Care Home

Detailed findings

Background to this inspection

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

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by two inspectors on 14 and 20 October 2022 and three inspectors on the 21 October 2022.

Service and service type
Madeira Lodge is a 'care home.' People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Madeira Lodge is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority, including their safeguarding team, and professionals who work with the service. We used all this information to plan our inspection. The provider did complete the required Provider Information Return (PIR). This is information providers are required to send us annually with key information about the service, what it does well and improvements they plan to make.

During the inspection
We spoke with four people who used the service about their experience of the care provided. We observed the care provided within the communal areas where we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with nine members of staff including the provider, registered manager, operational director, deputy manager, kitchen staff and care workers. We reviewed a range of records. This included nine people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

● People were not protected from risk of harm or abuse. We received significant concerns from a whistle-blower that people were being locked in their rooms at night. When we arrived at 5am, we found seven people had been locked in their room without their consent. Two rooms had been bolted from the outside. One of these rooms was on the second floor and the person's care plan confirmed they were unable to use a call bell for help placing them at significant risk of harm. The staff member who accompanied us around the building, did not have keys to open these doors and could not explain why they were locked.

● The registered manager said they were unaware this was happening and later during discussions with inspectors gave different reasons why rooms may have been locked. These included reasons such as protecting the person's belongings, or people had asked for the room to be locked so no other people could enter their rooms. We did not find any records to support these decisions.

● The registered manager told us they were unsure why staff had not come to them to raise the concerns above. However, we were concerned a culture of poor practice had developed within the service which meant staff may have recognised these but had not reported concerning unsafe practice by other staff.

● The provider and registered manager had not ensured any checks of the quality and safety of the service during the night were completed. This meant we were unable to determine how often people had been locked in their bedrooms, seriously compromising their ongoing safety and mental wellbeing.

● During the inspection we told the provider they must provide immediate written assurances about actions they would take to keep people safe and ensure they were not locked in their rooms without their consent. They provided us with an action plan to keep people safe which included reviewing management presence during the nights over the weekend.

The provider and registered manager failed to protect people from abuse and improper treatment. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

● During the inspection, doors were unlocked, and bolts removed from people's doors once the registered manager arrived on site. All people locked in their rooms had not come to physical harm but were at risk of serious harm to their mental health.

●The registered manager re-issued the providers safeguarding policy to all staff and asked them to sign to confirm they had read and understood the information contained.

Assessing risk, safety monitoring and management

● Risk to people receiving care and support were not consistently assessed or recorded. Where risks had been recorded, Staff were not using the information provided to safely assist people to move. We observed people being transferred with equipment that had not been assessed as suitable for them to use. For

example, one person was transferred from chair to wheelchair with a stand aid hoist when their care plan said they should be supported to transfer with assistance from two staff members and a walking frame. Another person was lifted by staff using a handling belt. The Health and Safety Executive states, "handling belts assist residents who can support their own weight, e.g. to help them stand up. They should not be used for lifting."

● People with health conditions which could impact their safety were not considered when risk assessing evacuation in an emergency or when making decisions about their care, such as people living with epilepsy.

● Risks to people who may fall were not consistently assessed and mitigated. One person was deemed as a medium risk of falls but had an extensive falls history. They had recorded in their care plan that they had 'few falls since being at Madeira lodge care home.' However, their electronic care plan had identified them as being at high risk of falls and had sustained 'four fractures' but contained no details of how these happened, what fractures they were and what impact this may have had on the care being delivered. The conflicting information and lack of clear risk management placed the person at risk of harm.

● People who were unable to use the call bell system for help were provided a floor sensor mat to mitigate risks. This was only appropriate if the person could independently get out of bed and stand to activate it. One person we reviewed had this equipment but was supported by staff with transfers meaning they did not have a way to call for help other than calling for help and staff hearing them. When we arrived on inspection, we heard this person calling out for help. They were not using the sensor mat.

● Some people living at the service were living with advanced dementia. Care plans detailed periods of heightened distress, but records did not consistently give staff the information or guidance on what to look out for, how to de-escalate these events to keep people and staff safe or provide positive support, for example one person was described as their mood can change very quickly. There was no detail for staff as how to support them in these situations.

The provider and registered manager failed to assess the risks to the health and safety of people or do all that was reasonably practicable to mitigate risks. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Staff were not deployed effectively to ensure people were kept safe and their needs were met. Prior to the inspection we received information in relation to staff shortages at night. During the inspection we identified four members of staff on shift, supporting 46 people during the night. The registered manager told us, there are normally five members of care staff working during the night, but they were unable to attend the shift at the last minute. One member of staff included in the numbers did not provide personal care.

● The registered manager used a dependency tool to determine the numbers of staff required to meet people's needs, However, we could not be assured that the information used to make this determination was accurate as people's needs had not been reviewed regularly and they did not consider when people may have periods of heightened anxiety or distress which required intervention from more staff.

The provider and registered manager failed to deploy staff appropriately. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● The recruitment records we reviewed showed staff were recruited safely. They had appropriate checks of work history, references and Disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Learning lessons when things go wrong

● A process was not in place to make sure lessons were learned from accidents and incidents to prevent future occurrences.
● Actions were put in place when concerns were raised however, the cause and potential reoccurrence of these failings were not considered meaning there was potential for things to happen again.
● Accident and incident records provided to us on inspection documented what had happened, for example a person had fallen and sustained a graze to their forehead. This had been signed by the staff who witnessed it but there was no record of the action taken or measures needed to prevent the incident happening again.

Using medicines safely
● People received their medicines as prescribed. We saw staff had signed medicine administration records after supporting people with their medicines. These records corresponded with the quantities of medicine left in stock.
● Temperatures of the clinical fridge were recorded and room temperatures for medicines were checked . This ensured medicines were stored at the correct temperature.
● People with medical conditions such as diabetes who require specialised medicines had these administered correctly and these were recorded in their medicines records.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
The registered manager was facilitating visits to people living at the home in accordance with current infection prevention and control guidance.

Inadequate

Is the service effective?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● The service was not always working within the principles of the MCA. Staff had a basic understanding of the MCA and could describe basic principles. However, people's rights were not always maintained in line with the MCA. Mental capacity assessments were poorly completed, and information was lacking in detail as to how the determination of capacity had been made.
● There were no mental capacity assessments, best interest decisions or applications for DoLS in relation to people being locked in their bedrooms at night. People had not consented to being locked in their bedrooms.
● People's ability to make decisions were not assessed and recorded consistently. Care records stated for One person that they did not have capacity to use the call bell system to call for assistance, but there were no assessment or records to demonstrate how this determination was made and what was required to ensure they could ask for help when needed.
● On the second day of inspection, we were informed two of the seven people locked in their rooms had been assessed and had capacity to make the decision they would like their room locked at night when they were in there. We reviewed the capacity assessments for both people. Both had been completed at the same exact time on the same day which did not evidence these assessments were individualised or had been completed properly.
● One person had four different mental capacity assessments for four different decisions completed at the same time on the same day which did not evidence the principles of the MCA had been followed.

● Three people had the same capacity assessment regarding being able to use the call bell system to ask for help. These were three photocopied records that had different names added in and were not personalised to the individual.

The provider and registered manager failed to put in to practice the requirements of the MCA, this is a breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were assessed, but the assessments were not always accurate and had not been kept under review. One person we reviewed had moved to the service in February 2022, but still had a short-term care plan containing only basic information and conflicting information. There was a full care plan in the file, but this had been completed by staff in the persons previous care setting, meaning staff did not have up to date information about the person's needs to support them appropriately in their current environment.
● Care plans we reviewed did not always contain important information such as medical history, next of kin information or resuscitation wishes meaning staff supporting people did not have the necessary information required to care for them effectively.
● The registered manager explained people's care files were in process of being transferred from written records onto the new electronic system. There was not a plan in place to ensure this transition was completed as effectively as possible, and therefore peoples assessments were held in different places which could lead to information not being reviewed and updated to ensure it was accurate.
● We received concerns people's care plans and assessments were locked in the registered managers office and staff at night were not able to access them. Although the registered manager explained there was a key to the office, this was not accessible to staff and was not available to inspectors when they arrived.

The provider and registered manager failed to ensure people's care and treatment was accurately recorded and updated to meet their needs and reflected their preferences. This is a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● Staff did not always demonstrate they were skilled and competent when delivering care. Staff received training via an online learning platform and three courses were face to face. There was no system in place to assess the quality of training staff received to ensure they had understood the content, test their skills, knowledge and competence to support people. This included assessing staff competence in helping people with limited mobility to move safely.
● Records showed staff had completed a range of training relevant to needs of people, such as moving and handling people, dementia and Mental Capacity Act 2005. However, these skills were not put into practice when interacting and caring for people. Staff did not demonstrate safe practice when supporting people to move and did not effectively support people with advanced dementia in a way that acknowledged and met their emotional needs. For example, one person was becoming distressed at another person following them. Both people came into the room that inspectors were using. Staff came and helped both people, however staff assisted them both out of the room together and left them in another part of the building. Shortly after both people came back into the room and one was particularly distressed at not being able to move freely without the other. Staff did not manage the situation effectively.
●There was no evidence provided to us during inspection to confirm staff had been trained in supporting people living with advanced stage dementia who may have periods of distress or anxiety. We raised this during our feedback process at the end of the inspection and the registered manager later supplied another training record with this recorded as completed, however we were not assured this training had been effectively utilised based on our observations.

The provider and registered manager failed to provide appropriate support, training and professional development. This is a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● Staff we spoke with during inspection told us they felt supported by the management team and knew how to raise concerns.

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

● People were not always supported to eat and drink enough. We did not observe a positive dining experience during our inspection. Our observations took place in the lounge. There were ten people present with nine sitting at tables. Some people were assisted to use the table, but others were holding their plates in their hands waiting for food with little interaction from staff who were present.

● People were offered a choice of main meals. Most people were served fish and chips however there were no offers of condiments such as sauces or salt and pepper. Ketchup was offered once meals had been served and most people had finished their meals.

● We observed one person who started to cough following their meal being served. Staff were attentive and offered support. They assisted the person to remove their dentures, but they still did not eat very much, and they appeared to be distressed. This incident was reported to the registered manager who contacted the Speech and Language Team (SALT) and medical professionals for advice. A medical practitioner visited the person and provided action for the staff to take on the same day.

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

● People were not always supported to access healthcare services and support in a timely way. We reviewed the person above who was having a period of coughing when eating food. Their care plan stated that, in July 2022, the dietician discharged them as they started to put on weight, but the instructions for staff were to re refer if the persons weight fell below 58kgs. This person weight was measured at 56.8kgs at the start of October 2022 and no referral had been made. When we fed this back to the registered manager on the second day of our inspection, they then made the referral. This placed the person at risk of further deterioration in their health.

● One person had been referred to the community mental health teams and the record of this was held in their file. Another had been reviewed by dietician with changes made to their dietary intake, However, not all people who required reviews by healthcare professionals had been appropriately referred and outcomes of these present in their care plans.

● People's oral health had been recorded in their care plan and information on what level of support people required from staff was detailed.

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

● The service was adapted and extended over time to allow for plenty of space for people to move around and a number of communal areas where people could choose to sit.

● There was signage so people who may lose their way were helped to get to where they wanted to be.

● People's names were on their room doors to help them know which room was theirs.

Requires Improvement

Is the service caring?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence

● People were not always treated in a dignified way. People were not treated with respect and compassion or given emotional support when needed. Although we saw some examples of staff treating people kindly, care delivered was not always respectful. The registered manager and staff referred to people as "wanderers", "fiddlers", "fidgeters" and "want attention."

● During our inspection, healthcare professionals visited to extract blood from one person. This was being completed in the lounge with other people present. Inspectors asked staff if this could have been completed in the persons bedroom for privacy and staff stated the person would not comply. We suggested a screen for times such as these, the registered manager informed us there was a screen, but staff were not using this to protect people's dignity during our observations.

● One person asked for the toilet stating they were desperate and was going to have an accident. The member of staff told them "not to be silly."

Ensuring people are well treated and supported; respecting equality and diversity

● People were not always treated well. Although we did see some occasions where staff were kind towards people , we also observed some people's nails which appeared to be unkempt and one person was eating with their hands. There were no prompts or assistance from staff to wash their hands before eating.

● We observed staff assisting one person into the lounge. Staff wanted to assist them to the lounge, and the person sat themselves in the dining room. The staff member proceeded to tell the person off and that they "did not listen" to them.

● One person was walking in the lounge and was causing distress to other people, pulling on other people's walking frames and their tables with little interaction from staff. In the afternoon a person was undressing themselves and several staff attempted to assist them but did not demonstrate that they understood how to do this in a person centred and effective way.

The provider and registered manager failed to ensure care was provided in a caring and dignified way. This is a breach of Regulation 10 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

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

● People were not involved in making decisions about their care. We reviewed recorded discussions the registered manager had about decisions regarding people's care and treatment. These did not evidence the person was involved and there was no involvement of people's loved ones to ensure the decision was in their best interest.

● Where people had no family involved in their care the registered manager had not always sought an advocate to support them with decision making.
● People were not actively involved in making decisions about the care they received. No evidence was available to show people had input into their care plans or were consulted on decisions surrounding their care.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

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

● Peoples care plans were not always personalised and did not ensure people had control and choice to meet their needs. People were referred to as "the resident" and the "service user" and some people's names were incorrect throughout their care plan.

● There was a care plan format in place. However, reviews of these had not been implemented effectively. People's care plans did not contain accurate information and had not been recently been reviewed. For example, one person's care plan was last updated in May 2022. This person had sustained an injury in July 2022 and had significant change in their mobility, but their care plan still reflected they could walk with support from staff. We later found this person required a full hoist for transferring and could not mobilise and this had not been updated in their care plan.

● Care plans did not always provide staff with the information they needed to ensure people received person centred care and treatment appropriate to their needs and personal preferences. They did not always address the types of and varying stages of peoples' dementia and how this affected their day to day living in terms of their independence and wellbeing. For example, one person had in their care plan that the moon affects their personality and they become more "argumentative" and "demanding." However, there was no guidance for staff to be able to support them or to provide positive support through these periods.

● Important, relevant and specific information to help staff deliver personalised and responsive support to people and promote wellbeing was not always present. There was not always detailed and relevant information to tell staff why an individual may become agitated or anxious, any triggers that might heighten their anxiety or ideas about how to distract or engage with them.

● The service had not fully embedded the use of their electronic care planning. Staff used hand-held devices for recording the delivery of people's care and support needs. However, this had not been used consistently. For example, some people's care plans were not recorded on the electronic system at all. This meant staff may not have had accurate information to support people the way the wished to be supported.

The provider and registered manager failed to provide appropriate support in a person-centred way. This is a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People were not supported to engage in activities which were socially or culturally relevant to them. The service employed one member of wellbeing staff to coordinate activities for the 48 people living in the service. Although, they tried to engage with multiple people at the same time in activities there was not enough time to provide meaningful interactions for everyone.

● We observed many people who were living with advanced dementia not having any stimulation or anything to do. Most people living at the service walked around the service and were not offered other things to do with little to no interaction from staff.
● The service employed a wellbeing coordinator who had made improvements in planning things for people to do. They told us, "It was hard at the start to get people to engage as they didn't have an activities coordinator before, so people weren't used to it." They arrange for activities to be planned through the week and at weekends people have "family time and films." The activity completed on day of our observations was colouring and had six people participating.
● Staff told us people who spend time in their rooms or who did not want to engage in the planned social activities have one to one time however, we did not see evidence of this.
● We saw photos displayed through the service of when people had been outside of the service to locations such as local zoo's, garden centres and churches. Also, there were displays of activities such as, entertainers, baking, dancing, doll therapy, arts and crafts and people completing jigsaws.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● Where people required support with their communication these were recorded in people's care plans.
● One person living at the service did not use English as their first language and the registered manager told us they had taken extra steps to communicate with them. Such as arranging an interpreter so their needs and wishes could be identified.
● We saw evidence that one person used pictures to communicate effectively with staff.

Improving care quality in response to complaints or concerns
● The provider had a system in place to handle complaints effectively and complaints received had been investigated and responded to appropriately.

End of life care and support
● The registered manager confirmed they were not providing end of life support to anyone at the time of our inspection
● People's care plans included information about their end of life support preferences, such as religious requirements, wishes about their final days and what they wished to happen following their death, where people had been happy to discuss this with staff.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- There was a lack of an open and honest culture within the service. Staff had not raised concerns regarding the treatment and safety of some of the people living at the service. Staff working when people were locked in their rooms had not raised this to the registered manager or followed the providers policy on raising safeguarding concerns.
- The registered manager could not be assured that welfare checks had been completed for people that needed them. For example, during the night time, we were told all people living at the service required two hourly checks, however there was no accurate record to confirm the checks were being carried out and at what time.
- During feedback to the registered manager about the doors we had found to be locked, they told us there were some mornings in the weeks prior, where they felt something may have been wrong as there was a negative atmosphere when they arrived. However, the registered manager did not investigate this further which placed people at continued risk of harm.
- The registered manager told us on our second day of inspection they had noticed a difference in some members of staff morale and attitude since action had been taken following the first day of inspection. However, the provider and registered manager continued to maintain there was not a culture of poor practice throughout the service.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The provider's system for governance had not been effective in identifying the issues we found during this inspection. They had failed to identify shortfalls and breaches of regulation in relation to risk management, safeguarding concerns about people during the night, care plan reviews, mental capacity, and dignity and respect.
- No out of hours safety checks had been completed. These unannounced checks, normally completed by the registered manager or delegated to staff, should be in place to ensure people were being supported in a safe and caring way when the management team have left the service, reducing the risk of abuse.
- Records were of poor quality and did not include a complete and accurate record of care provided or have guidance for staff to provide care in a personal way. Information which was incomplete or inaccurate was identified by the operational director's monthly audits, but these had not been followed up to ensure action was taken. For example, and audit completed in July 2022 had identified a person's care file was inaccurate

and did not hold important information since February 2022, we identified the same issues during our inspection.

The provider and registered manager failed to operate a robust quality assurance process to continually understand and have oversight of the quality of the service and ensure any shortfalls were addressed. The provider and registered manager failed to maintain accurate and complete records in relation to the service and people's care. This placed people at risk of harm. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Registered persons are required to notify the Care Quality Commission (CQC) about events and incidents such as abuse, serious injuries and deaths. The provider and registered manager understood their role and responsibilities and had notified CQC about all important events that had occurred.
● It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. The provider had displayed a copy of their rating in the service and on their website.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● People had been referred to health and social care professionals where required however, We received mixed feedback about the implementation of advice given to the service.
● The provider and registered manager engaged with people and their relatives through regular meetings and told us that feedback was always positive. However, we did not review records of these meetings.
● The registered manager told us they were involved in local networks, worked alongside the local colleges and schools and frequently visited the local dementia café to share their knowledge.