J D Singh

Belvedere Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected this service on 23 and 24 February 2017. The inspection was unannounced.

The service provides accommodation and personal care for up to 19 older people. Fifteen people were living at the home at the time of our inspection.

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

At our previous inspection in April 2016, we found a breach of the regulations, related to obtaining people's consent to care and we gave the home an overall rating of requires improvement. The provider agreed they would make the required improvements and would regularly monitor the quality of the service, to ensure people received safe, effective and responsive care and support.

At this inspection, we found the required improvements had not been made. We have invited the provider and registered manager to meet with us to explain how they will make the required improvements.

The registered manager continued to deliver care and support that restricted people's liberty, but had not applied to the supervisory body for the authority to do so. This was a continuing breach of the regulations.

The provider and registered manager had not implemented an effective system to monitor the quality of the service, although they had agreed they would do so after our previous inspection. They had not taken all reasonable measures to minimise risks to people's health and wellbeing.

Since our last inspection, no improvements had been made in checking that staff updated people's care plans effectively when their needs, abilities and daily records were reviewed. The registered manager was not able to demonstrate that they had used an analysis of people's current needs and abilities to ensure there were enough suitably skilled and experienced staff on duty to maintain people's health and well-being.

No improvements had been made in ensuring people's care plans centred on the person and their needs, wants or preferences. This resulted in staff continuing to be focussed on tasks, instead of delivering person-centred care. Activities were arranged, but they were not specifically matched to people's individual interests or their abilities to engage as a group or their needs for one-to-one engagement.

Accidents, incidents and falls were investigated and actions taken to minimise the risks of a re-occurrence for the individual, but improvements were required in the overall analysis of accidents and incidents to identify any service wide contributory factors.

Staff were kind and compassionate and enjoyed working with people at the home. Staff's understanding of their responsibilities and their willingness to spend time with people was variable, according to relatives that visited the home regularly.

The registered manager's decision to deliver 'hands-on' care to cover staff sickness absence continued to take up time they needed to spend on managerial tasks. Not all staff respected the manager's authority and there were gaps in the audit checks staff were asked to make. Gas and water supplies were regularly tested and serviced, but the registered manager was not able to demonstrate that the water supplies and fire protection system were regularly checked and functioning safely.

People's medicines were managed and administered safely. People were supported to maintain their health and were referred to healthcare professionals when needed. People were supported to eat and drink enough of foods they liked.

People were safe from the risks of harm, because staff understood their responsibilities to protect people from harm and were encouraged and supported to raise concerns under the provider's safeguarding and whistleblowing policies.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe. People's written care plans were not updated to include changes in people's needs and abilities that care staff knew about. Staff understood their responsibilities to keep people safe from abuse. People's medicines were managed and administered safely. Risks related to the temperature of the water supply and to fire alarm equipment were not managed consistently. There were enough staff to support people safely.

Is the service effective?

Requires Improvement

The service was not consistently effective. The registered manager had not understood their responsibilities under the Mental Capacity Act 2005. They had acted in people's best interests to keep them safe, without applying to the supervisory body for the authority to deliver care that restricted people's liberty. Not all staff displayed the skills and understanding to support people effectively. People were supported to eat and drink enough for their needs. People were supported to maintain their health and were referred to healthcare professionals when needed.

Is the service caring?

Good

The service was caring. Staff enjoyed working with people and supported them with kindness and compassion. People were supported to maintain their dignity and respect.

Is the service responsive?

Requires Improvement

The service was not consistently responsive. Staff's knowledge of changes in people's needs and abilities was not always reflected in their care plans. Staff knew people well and understood how to respond to their physical needs and temperament. Staff supported people to spend time socialising with others, but did not always offer support that centred on their individual needs. The process for obtaining people's and relatives' views of the service was not effective. Relatives concerns were not used to improve the quality of the service.

Is the service well-led?

Requires Improvement

The service was not consistently well-led. The registered manager did not have sufficient time to provide effective leadership and oversight of staff's practice. Delegated management tasks were not always carried out by staff as instructed. The registered manager did not have sufficient management time or effective support from staff or the provider to make sure risks to people's health and well-being were minimised. The provider had not ensured an effective quality monitoring system was implemented.

Belvedere Residential 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 was planned to check 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 23 and 24 February 2017 and was unannounced. The inspection was undertaken by one inspector and an expert-by-experience on 23 February 2017 and by an inspector on 24 February 2017. An expert-by-experience is a person who has personal experience of using, or caring for someone who uses, this type of service.

We reviewed the information we held about the service. We looked at information received from relatives, the local authority commissioners and the statutory notifications the registered manager had sent us. A statutory notification is information about important events, which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services, which are paid for by the local authority.

We spoke with nine people and three relatives about what it was like to live at the home. We spoke with four care staff, a cook and an administrator about what it was like to work at the home. We spoke with the registered manager and the deputy manager about their management of the service. We observed care and support being delivered in communal areas and we observed how people were supported at lunchtime.

Most of the people who lived at the home were not able to tell us in detail, about how they were cared for and supported because of their complex needs. However, we used the short observational framework tool (SOFI) to help us assess whether people's needs were appropriately met and to identify if people experienced good standards of care. SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

We reviewed three people's care plans and daily records and to see how care and treatment was planned and delivered. We checked whether staff were recruited safely, and trained to deliver care and support appropriate to each person's needs. We reviewed the results of the provider's quality monitoring system to see what actions were taken and planned to improve the quality of the service.

Requires Improvement

Is the service safe?

Our findings

People who were able to express their feelings verbally told us they felt safe at the home. A relative told us, "It feels safe here. I have not had any concerns." We saw that people seemed relaxed and comfortable in staff's company, which indicated they felt safe with the staff.

The registered manager knew about their responsibilities to protect people from the risks of abuse. They had notified us when they made a referral to the local safeguarding agency and made sure staff received training in safeguarding. Staff told us they understood their responsibilities to protect people from harm. Staff told us, "I would not let staff get away with anything. If I saw anything I thought wasn't right, I would tell the manager" and "I know to report concerns to the manager, CQC or social services."

People's needs and abilities were assessed before they moved into the home, and risk assessments were completed to identify their individual risks. People's care plans included the actions staff should take to minimise the identified risks. For example, one person was identified as at risk of not being able to maintain their personal hygiene independently. Their care plan named each part of the body they needed assistance with and how many care staff were needed to assist them safely.

During our previous inspection we found improvements were required in accurately identifying people's changing needs and abilities and in updating people's risk assessments and care plans. During this inspection, we found the required improvements had not been made. People's care plans were not always updated accurately to minimise risks to their health and well-being. For example, one person's care plan said they liked to get up between 8am and 9am. However, the person's needs and abilities had changed and they were cared for in bed all the time.

Another care plan we reviewed said the person was at risk of epileptic seizures. The care plan instructions for staff, in the event the person suffered a seizure, was dated December 2015, and was to "position for clear airways" and "if any problems, call 999".The care plan did not explain what a "problem" would look like or how long staff should wait before calling 999. The risk assessment and care plan for supporting the person had not been considered or updated following a review of another section of their care plan in December 2016. The other section clearly stated that the person "cannot be turned", which was contradictory to the instruction to 'position to clear airways'. Although a member of staff told us the person had not had a seizure for a long period of time, this was not clearly recorded when their care plan was reviewed. There was a risk staff could have acted in a way that was detrimental to the person's health, in the event they suffered an epileptic seizure.

The provider had taken some action to minimise risks to people's safety relating to the premises. Records showed the gas supply and installation were regularly checked for safety by a qualified professional. The provider had obtained advice for checking that taps and showers ran at a safe temperature. The registered manager had a booklet that included guidance for the frequency of checking individual water outlets and the maximum temperature they should run at, to minimise the risk of scalding. However, the member of staff who was delegated to conduct the checks had not followed the guidance. They did not know what the

recommended frequency for checking was, and did not know what the maximum temperatures should be. Records showed that water temperatures were not checked in accordance with health and safety guidance. The provider and registered manager could not be confident that risks of scalding were minimised.

Improvements were needed in ensuring risks to people's safety in the event of a fire were minimised. Records showed the provider had engaged the services of an external professional in assessing the risks of fire. The provider had agreed to a regular schedule for servicing fire-fighting equipment and for checking the fire safety measures they had installed. However, not all staff had maintained the schedule of checks that were delegated to them. For example, the member of staff who was responsible for checking the emergency lights worked, had only 'visually' checked them until April 2016, when they then stopped their checks without informing the registered manager. The registered manager had recognised this misunderstanding when they had reassigned some delegated duties to another member of staff. Effective checks, which included switching the lights on and off to test them effectively, were re-instated in January 2017.

Records showed the registered manager made sure staff received fire safety training and arranged regular fire drills, when all staff on duty went to the designated 'collection point' and talked through what they would do in the event of a fire. One member of staff told us, "I would await instruction by a senior. They would identify the safe zone." However the member of staff did not know which doors were fire doors that would close automatically in the event of the alarm going off. We saw that people's personal emergency evacuation plans were kept in a cupboard in an inner room that was behind two fire doors. This meant that information the fire service might need to know was likely to be inaccessible in an emergency.

Staff were recruited safely because the registered manager checked they were of good character before they started working at the home. Records showed the registered manager had obtained references from previous employers and checked whether the Disclosure and Barring Service (DBS) had any information about them. The DBS is a national agency that keeps records of criminal convictions.

There were enough staff to support people safely, but not all staff demonstrated skill at supporting people to move safely. During our previous inspection we identified that improvements were required in supporting people to move from one place to another. During this inspection, we found improvements were still required in some staff's skill and understanding, which was variable. For example, one member of care staff supported a person to move from their armchair to a wheelchair, but they had not applied the brakes before the person sat in the wheelchair. There was a risk it could have moved away from the person as they sat down.

People were supported with personal care and encouraged and supported to move to the dining room for meals. Relatives told us the staffing levels and roles were not always clear and one relative said, "Sometimes it seems understaffed due to sickness." On the first day of our inspection visit, the registered manager was covering staff sickness absence. They told us another member of staff they might have asked to cover was not available, so they were working 'hands-on' with people that day.

On the second day of our inspection visit, the deputy manager was on duty to cover sickness absence, which enabled the registered manager to safely check in people's medicines, which had arrived that day. Staff told us, "There are enough staff. We are four empty bedrooms so there are plenty of staff" and "Two care staff and one senior is enough. It is okay if we are well organised. We can do everything in the mornings and later we have activities."

A senior member of care staff showed us how people's medicines were managed and administered safely. They told us that only named staff who were trained in medicines were able to administer them. Medicines

were kept in a locked, temperature controlled cupboard. We saw staff monitored the temperature of the fridge, to make sure medicines were kept the right temperature according to the manufacturer's guidance. Most medicines were delivered in 'bio dose' pots, which contained all the medicines a person required at the same time of day in one sealed pot. The pots were contained in trays, colour coded for the time of day and included a photo of the person, a list of medicines in each sealed pot and the purpose of the medicine. A member of staff told us if any medicines were stopped by the GP, they sent the whole tray back to the pharmacy, who amended the contents and returned the tray the same day.

The pharmacy supplied a separate medicine administration record (MAR) for each person. Staff signed the MARs to record when people had been given their prescribed medicines, or used an agreed code to explain why the medicine had not been given. If a medicine was not administered, staff recorded on the back of the MAR sheet why not. The two MARs we looked at were signed and up to date in accordance with the prescriptions. The member of staff assured us, "You must sign after, not before (administering medicines)." Medicines that were prescribed 'as and when required' were delivered in their original packaging. Staff kept a count of the number of tablets administered and remaining, to make sure they were all accounted for and re-ordered when necessary.

For two people who regularly declined their medicines, and who did not have the capacity to understand the risks of not taking their medicines, their GP had agreed their medicines could be given covertly in their best interests. Covert medicines are given without the person's knowledge, mixed in food or drink. Although one person's medicines had been checked to confirm the type of food or drink it was suitable to be crushed into, the other person's had not. The registered manager told us they would contact the pharmacy straight away for advice about which food or drinks were suitable for their prescribed medicines to be crushed into and administered with. .

A member of staff told us people were able to say if they wanted pain relief medicines, and they monitored people's body language and facial expression to assess whether they were experiencing any pain. They told us they wrote down the time pain relief was administered to minimise the risks of the person receiving too much medicine in too short a timescale. They told us if anyone was prescribed nourishing drinks to supplement their diet, the drinks would be included on the MAR sheet to make sure they were not overlooked at meal times. The member of staff told us the registered manager regularly audited the medicines trolley to check that people received their prescribed medicines when they needed them.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards.

During our previous inspection we identified that the registered manager had not understood the requirement to obtain the legal authority to safeguard people when they were deprived of their liberty (DoLs), or to restrict their freedom to do what they wanted to keep them safe in their best interests. After that inspection, the registered manager sent us evidence that they had applied to the local supervisory board for the proper authority to restrict two people's freedom in their best interests. However, at this inspection we found the registered manager had not applied their learning from our previous conversations to consider whether other people were being deprived of their freedom in their best interests.

The registered manager told us no-one would be 'allowed' to leave the home independently, because no-one had the capacity to understand the risks of going out alone. They told us that staff also knew where everyone was all the time. For example, staff always escorted people from their bedroom to the lounge, to the dining room and back to their own room at the end of the day. People who were able to walk around independently were always with hearing range of staff and staff always knew where they were. This meant that people's care and support met the test for being deprived of their liberty, that is, they did not have the capacity to consent to their freedom being restricted, they were not free to leave the home independently and were under continuous supervision. The registered manager had not applied to the local supervisory board for the authority to deprive people of their liberty in their best interests.

This was a continuing breach of Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2014 Need for consent.

Staff understood their responsibilities under the Act. A member of staff told us, "I know it is to protect people from risks, because they may not understand the risks. We make best interest decisions. (For example), we try to explain the importance of eating. We keep offering and explaining why it's important." We saw staff checked people wanted their assistance, before supporting them.

Staff told us they felt prepared to work with people because they had training during their induction to the home. They told us when they started working at the home, they observed experienced staff and got to know people, so they could understand their individual needs and abilities. A member of staff told us, "I shadowed first, I was introduced to everyone, and had training. Then I felt ready." Staff told us they received training that reflected people's needs and enabled them to support people safely and effectively.

Records showed new staff completed a training programme designed to meet the fundamental standards of care in accordance with the Care certificate. The Care certificate is a nationally agreed set of fifteen standards that health and social care workers follow in their daily working life. It was launched in April 2015 and providers regulated by the CQC are expected to ensure that the standards are covered in their induction of new staff. The registered manager observed staff's practice during their probation period to check they used their training to engage with people effectively.

One person who was living at the home for a short stay told us, "Staff look after the people who live with dementia alright and the other residents seem happy." However, some relatives voiced concerns about the variability in staff's effectiveness. One relative told us, "There's a big difference in the care offered during week days and at weekends. At weekends, staff don't always take residents to the dining room, or take the residents to the toilet quickly."

One member of care staff who supported a person to move from the dining room to the lounge after lunch appeared to concentrate on the task of supporting the person to move, rather than the person's comfort. They did not make sure the person was sitting comfortably and securely before moving away. The person was sat in the chair of their choice, but they were not sitting straight in the chair. They had not been supported to place their feet centrally on the footstool next to their chair and one leg was leaning on an open door at their side. The person's foot slipped off the stool, before the member of staff had moved away. Two staff then needed to adjust the chair and the person's position. We later saw the person was sat comfortably, securely and safely in their seat. The registered manager was supporting other people and did not see the staff's practice.

People were supported to eat and drink enough for their needs. People were offered a choice of hot and cold drinks throughout both days of the inspection. The registered manager told us they asked people about their food likes, dislikes and preferences at their initial needs assessment. They recorded the information in people's care plans, planned the menus accordingly and shared the information with the cook.

The cook told us they went round to each person every morning to ask which meal on the day's menu they would like for lunch. They showed us the four-weekly menu, which included two different main meals each day. They told us if people did not want either meal on the menu, they could have, "An omelette, scrambled eggs, chips or whatever they want." They told us everyone had chosen the same meal that day, so they had only prepared one main meal. The cook also had a list of people's dietary needs, which included their allergies, religious and cultural preferences. They told us, "[Name] does not eat beef, but no one is currently on a lactose free, gluten free, vegetarian or kosher diet."

At lunch time we saw people were supported to go the dining room, where relaxing music was playing. The cook served up each meal in the kitchen according to each person's choice and told staff the name of the person they should serve the meal to. A relative told us, "I believe people have a meal choice every day with a hot or cold option at teatime." One person told us they could not remember being given a choice. We saw the person declined to eat the main meal and was offered a different meal of their choice. People appeared to enjoy their meals and were assisted when needed, for example with cutting up their food.

People were regularly weighed and staff monitored how much people ate and drank if they were at risk of poor nutrition. People were referred to dieticians or speech and language therapists when they showed signs of needing professional healthcare support to maintain a balanced diet.

Records showed people were supported to maintain their health and were referred to healthcare

professionals, such as opticians, dentists, chiropodists and GPs, when needed. During the shift handover, staff shared information about changes in people's moods, appetites and behaviours, in case the changes were a sign of ill-health. District nurses regularly visited some of the people at the home to support with managing their diabetes. The registered manager told us people who were not able to communicate well verbally, were supported by staff when other healthcare professionals visited them, to ensure effective communication between the two parties.

Good

Is the service caring?

Our findings

People appeared to be happy at the home and their facial responses to staff's offers of support showed they trusted staff to treat them kindly and fairly. A relative told us they like the atmosphere because, "It felt like home from home" when they first visited. A member of staff told us, "It's a relaxed home. People are content and happy."

We saw care staff knew people well and were kind and thoughtful to them. For example, when one person told a member of staff they were 'chilly', the member of staff offered to fetch a blanket for the person's knees. Staff were patient with people and understood the importance of promoting people's independence. For example, we heard one person laughing as a member of staff said, "Push there. Are you ready", while supporting them to stand up. Staff told us they liked working at the home because, "I'm really involved. I know them like my family" and "I see myself as their friend. You can't help but get attached."

Staff told us they had training in dementia awareness, which helped them understand how people who lived with dementia might feel, even if they were unable to express their thoughts verbally. Staff showed empathy and demonstrated skill at supporting people who lived with dementia. For example, when one person started laughing without an obvious reason, staff smiled along with them, which enabled the person to share their emotions, even though they could not share their thoughts.

People who were able to understand and agree how they were cared for and supported had signed their care plan. Staff told us they were 'keyworkers' for individual people, which meant they attended to all the individual's personal needs, reviewed their care plans and made, "A special relationship with their family." They told us families seem pleased to see them, because they represented the person and were able to share information that the person might not remember, or be able, to tell them. Staff told us when people showed a preference for being supported by a particular member of staff, they tried to allocate them to work with that person for personal care, to maximise the level of trust between them. Staff demonstrated a good knowledge of people's individual needs, abilities and preferences, when they described how they supported them.

The registered manager understood some aspects of involving people in decision making and of respecting people's individuality. Every bedroom was decorated with a different style of wallpaper. Every time a new person moved into the home, their bedroom was re-decorated and a new carpet was laid in advance, which promoted feelings of ownership of the room by the individual. The registered manager told us, "I like to give people a bit of luxury, to make it the best they might have had." They showed us one bedroom that the person's relative had decorated themselves. They told us it had given pleasure to the person and their family to be included in making decisions about their home.

Staff respected people's privacy and dignity and promoted their independence. Staff spoke discreetly with people when offering assistance with personal care, and we saw people's hair was brushed and their clothes were clean. People were offered clothes protectors at lunch time, and were supported to change into clean clothes after their meal if they had spilled any food or drink. One person told us a hairdresser visited the

home regularly and they saw the difference the hairdresser's visits made to people's self-esteem.

We saw staff responded sensitively to one person's needs for emotional privacy after receiving upsetting news about their family. The person chose to spend time alone in their room rather than joining other people at lunch time. Staff respected the person's needs and the person was served their lunch later than other people.

Requires Improvement

Is the service responsive?

Our findings

During our previous inspection, we found improvements were needed in responding to people's individual needs. During this inspection, we found improvements were still needed

Care staff told us they reviewed the care plans for the people they were keyworkers for. The reviews we saw did not always include changes to people's care plans. The registered manager told us they had instructed staff to, "Work right through from front to back" of each care plan, but they had not checked that staff did as instructed. A member of staff told us each member of staff was responsible for reviewing one care plan each, but, they said, "There is no oversight of care plan reviews."

Improvements were needed in assessing people's psychological needs and dependencies to inform the level of staffing. Relatives shared their concerns with us that because staffing was 'minimal', staff were more task focussed than people focussed and that people spent significant periods of time sat around waiting for staff to spend time with them. One member of care staff agreed that, "Probably more staff would give people a nicer life. I would want to go out, be outside." They told us, if they had more time they would, "Do more, go to the shops, day trips, do baking."

During the first day of our inspection visit, we saw staff were not deployed effectively according to people's needs. We saw three people waited 30 minutes between finishing their lunch and leaving the dining room. One person shouted out, "How long before I can leave the dining room?" We did not hear or see an explanation of why they had been kept waiting. One person was brought into the dining room in a wheelchair just after twelve o'clock, ready for lunch at 12:30pm. The person was last to leave the dining room at 2.55pm, when they were supported to go to their room for bed rest. Staff had not considered how the person might entertain themselves while they waited for staff's support. There was nothing on the table to occupy the person between finishing their meal and waiting to go to their room. A relative told us, "There's not much stimulation. I guess that's why we like to come and keep [Name] company."

Some external organised activities took place most weeks, such as music and movement, visits from a hairdresser and manicurist, but the activities did not always match people's needs or interests. One person who lived at the home told us, "A lady came yesterday with a balloon activity. She wanted everyone to join in. I felt like a big kid to be honest."

There were no magazines, newspapers, reminiscence books or memorabilia to engage people in world events or their surroundings. A relative told us, "I am thinking of asking them to ask the local library about reminiscence books for [Name]." A member of staff told us they 'did activities' with people in the afternoon, such as making cards together, hairdresser visits and watching television. We saw staff singing, dancing and making music with people as a group for almost an hour in the afternoon of the second day of our inspection. People enjoyed the music and joined in, smiling and laughing with staff.

A member of staff told us, "We use people's photo albums in their rooms to talk about their lives. We chat with people while supporting them to shower," but the time spent on personal care and showering was a

small proportion of people's day. We did not see staff encouraging people in one-to-one activities that related to their individual interests. People's care plans did not include information about their previous lives, hobbies or relationships, to support staff to understand their interests and motivation. The registered manager agreed, "We need to review the life history work and re-instate it in people's care plans." They showed us one person's care plan which contained a family tree and information about their previous life, which care staff could use to support the person to reminisce, but this kind of information was not included in everyone's care plan.

Improvements were needed in obtaining and responding to people's views of the service. People's views of the service were made known through the one-to-one conversations with staff while being supported with personal care, and during infrequent group meetings in the lounge. Records of the group meetings did not say how many people were in the lounge at the time or how many people were actively involved in the discussions, independently or with support from staff. The person leading the meeting had asked a series of questions, without considering whether people were able to understand and give a considered response to a series of questions. The minutes of one meeting recorded the word 'silence' as people's response to three questions, but the meeting leader had not explored this further by rewording the questions or, for example, by using pictures to support people's understanding.

The conclusion of one of the recorded meetings was, "A few residents said they would enjoy watching old movies" and "We have some in the store, so will ensure they have a movie in the afternoon." During our two day inspection, no movies were shown in the lounge. The television was on and a member of staff told us which person usually chose the programmes, because they were able to change the channel themselves. This did not take account of other people's preferences. Only three people appeared to pay any attention to the television and two of those three people were sitting sideways to the screen. They had to twist their heads or bodies to watch it. Staff did not suggest they move seats, or that the television could be moved, to suit those people who wished to watch it.

Visitors told us they felt welcomed to visit their relations when they wanted to. Two relatives told us, "We are welcome any time of the day or evening and that is very important to us" and "We've not had any concerns." None of the people or relatives we spoke with had made a formal, written complaint.

The registered manager told us no complaints had been received since our previous inspection. they showed us the complaints log they had implemented to capture informal complaints, called 'grumbles', but this contained no new records since our previous inspection. Despite the lack of records, one relative told us they had raised several issues, but felt that any concerns were, "Swept away" by the registered manager. This meant the registered manager's plan to capture informal complaints to drive improvements in the quality of the service had not been implemented.

Requires Improvement

Is the service well-led?

Our findings

During our previous inspection, we identified improvements were needed in the management and leadership of the service. At this inspection, we found the required improvements had not been made. The registered manager continued to deliver 'hands-on' care to support people and staff when staff were absent due to sickness. Their hands-on approach was effective in supporting people's day-to-day needs, but limited the amount of time available to attend to managerial tasks and responsibilities.

On the first day of our inspection visit, the registered manager was working alongside care staff to cover for staff sickness absence. On the second day of our visit, the deputy manager was delivering 'hands-on' care for to cover staff sickness absence, while the registered manager checked-in people's medicines, which had arrived that day. This work took the registered manager away from their managerial duties for two consecutive days that week. A relative told us they were frequently not able to speak to the registered manager in their managerial capacity, because they were busy with 'hands-on' care.

The registered manager had worked at the home for 17 years. They told us they loved working with people and that was why they had remained in post. Staff told us they liked working at the home, and they respected the registered manager's skills and experience. However, more senior staff were concerned that individual members of staff did not respect the registered manager's authority and said some staff continued to do as they thought best, regardless of the changes the registered manager tried to implement.

The deputy manager told us, "There is overlap where it is not needed and gaps at management level. Staff work to custom and practice. I have been a senior here for 20 years and a deputy for one and a half years, but am still doing a senior's role." The deputy manager told us they were always on the rota to deliver 'hands-on' care and did not have sufficient support with clerical tasks.

The registered manager did not have sufficient time to check whether the staff they delegated some of their managerial tasks to had an effective understanding of what they needed to do and why it was important. Regular safety checks had not been completed in accordance with health and safety guidance. Staff had made limited safety checks in line with their own assessment of the risks, not in line with the registered manager's instructions, and the registered manager had not checked the staff's reliability or understanding. The registered manager could not be confident that risks related to the temperature of the water and the fire alarm system were minimised.

The registered manager had not made the improvements in monitoring the quality of the service that they had agreed were needed at our previous inspection. Care plans were still not sufficiently detailed and up to date to give an accurate picture of people's care needs and how staff should meting them. The registered manager had not checked that the care plan reviews undertaken by staff were effective and reflected people's current needs. In the absence of an analysis of people's needs and abilities, the registered manager was not able to ensure there were enough staff to meet people's needs safely and effectively. People and relatives told us staffing levels and roles were not always clear and they felt at times there were not enough staff to meet the people's various needs. A relative told us they were not confident that staff were deployed

effectively when the registered manager was not at the home to oversee the service.

People and relatives had not been invited to share their views of the service formally through meetings or surveys. A relative told us they had concerns that staff did not spend enough time engaging with people and supporting them to live a fulfilling life. They had not shared their concerns with the manager, because they thought the manager would have identified this themselves. Instead they visited more frequently than they had thought they would, to ensure their relation was received emotional and intellectual stimulation. Another relative told us they had shared their concerns about staff's lack of awareness of and response to people's needs, particularly at weekends when the registered manager was off duty. The relative told us, "Staff say they don't have time, but they spend time in the dining room, chatting on phones, not chatting with people." The relative told us the registered manager had not responded to their concerns in the way they had expected. The relative's concerns, and registered manager's actions taken as a result of their concerns, were not recorded in the complaints or 'grumbles' book, and were not included in a formal quality monitoring process.

Other relatives told us the manager was approachable and responsive, but they were concerned that the quality of care and choices, and the atmosphere, were different at the weekends when the registered manager was not there. A relative told us people were not always encouraged to have meals in the dining room and were not supported with personal care as frequently at weekends as they were in the week. They said they heard staff arguing in the dining room and discussing people's personal affairs within earshot of other people in the dining room and in the corridor. One relative told us, "It doesn't feel so nice at weekends." People and relatives views were not regularly sought as part of the provider's quality monitoring system, which meant the registered manager was not able to make changes to improve people's experience of the service.

Care staff kept a record of how much people ate and drank if they were at risk of not eating or drinking enough. For two people who were cared for in bed, we saw the records were kept in their bedroom so senior staff could check people were supported effectively. However, senior staff did not countersign the records, to demonstrate they had checked staff's practice. The senior told us they looked to check that drinks were regularly offered and drunk, but they did not calculate how much a person ate or drank in total. It was not clear that the frequency with which drinks were offered was sufficient to be confident that people drank enough because no-one was totalling people's fluid intake or monitoring fluid intake against a recommended target.

Staff training records were listed one-by-one, but not analysed to identify gaps in staff's training. The administrator and registered manager had not recognised that collating staff training records would be useful to identify when refresher training was due, and to check whether staff training was effective. The registered manager had not spent time recently observing staff's practice from the point of view of people who lived at the home, or their relatives, to identify gaps in staff's understanding and implementation of their training.

The administrator had been tasked with analysing accidents, incidents and falls records. They had kept a log of each incident and documented whether the action taken by staff on each occasion was appropriate and effective in supporting the person afterwards. However, they had not analysed the information by the person's name, the time of day, the location or any other aspect. They had not used the information to identify any patterns, causes or triggers and whether they were unique to the person or caused by the environment. The registered manager had not been given the information they needed to take assess whether action was needed to reduce the risks of recurring accidents, incidents or falls.

The registered manager showed us the checks they made of staff medicines management and administration. The registered manager told us they counted every medicine in the cupboard and matched the count to the records staff made every time they administered medicines. However, the records they kept of this valuable audit just showed the dates they had completed the checks, which were marked, 'no gaps' and 'no errors'. The system they used to audit medicines was not suitable to be delegated to senior staff or the deputy, because it was not written down. There was a risk that checks on medicines administration could not be undertaken effectively in the registered manager's absence.

The provider had responsibility to ensure the registered manager and their team carried out their responsibilities safely and effectively to meet the CQC regulations. We were aware the provider discussed issues with the registered manager but we did not see any formal systems and processes used by them to assure themselves that the home provided a quality service.

After our previous inspection we recommended that the provider supported the registered manager by developing formal monitoring processes to assess and improve the quality and safety of the service. During this inspection we found they had not implemented formal quality monitoring systems. The provider had not taken reasonable measures to minimise risks to people's safety and wellbeing.

This was a breach of Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good governance.

We have invited the provider and registered manager to a meeting to discuss these issues so that they can tell us how they will improve.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered manager had not applied to the local authority for Deprivation of Liberty Safeguards, for people who lived at the home who did not have capacity and whose freedom was being restricted.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider and registered manager had not established and operated effective systems or processes to enable them to assess, monitor and improve the quality and safety of the services provided, including the quality of the experience of service users in receiving those services, and to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk.