Eminence Care Service (Broomfield) Limited

Broomfield Residential Care

Inspection report

Yardley Road
Olney
Buckinghamshire
MK46 5DX

Tel: 01234711619
Website: www.broomfieldcare.co.uk

Date of inspection visit:
14 January 2020

Date of publication:
25 March 2020

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Broomfield Residential Care is a care home providing personal 30 people aged 65 and over at the time of the inspection. The service can support up to 40 people.

People's experience of using this service and what we found
People's wellbeing and safety was placed at risk as care was not always taken when people received their medicines. Cleanliness, hygiene and infection control practices were not always maintained to a good standard to protect people from the risk of the spread of infection.

People were not actively encouraged to be involved fully in planning and reviewing their care. People's care plans had been updated although in some instances lacked personalisation with regards to their hobbies, daily routines and the gender of staff to support them. People's privacy, dignity and independence was not fully respected and promoted by staff. We observed some positive interactions and kindness shown by staff towards people.

The service had a registered manager. Whilst they understood their legal responsibilities they had not kept their knowledge up to date in relation to best practice guidance in relation to medicines management and infection control practices.

The provider's quality assurance systems and processes remained ineffective and lacked oversight. Audits and daily visual checks were carried out daily by the registered manager did not identify the issues we found in relation to hygiene, cleanliness, environmental risks. Information in the care plans varied and lacked about individual preferences and daily routines. People, their relatives and staff were not confident their concerns would be taken seriously. They found the registered manager was neither visible or approachable.

People's views about the staffing numbers were mixed despite the increased numbers of staff on duty. Although people said their needs were met staff were often stretched at busy times and relied on the activities coordinator to supervise people in the communal lounge.

Staff recruitment procedures were followed, and all necessary pre-employment checks were carried out. Staff received training for their roles and were supervised.

People told us they felt safe and were confident staff would protect them from avoidable harm. Staff were trained in safeguarding procedures and knew how to raise concerns. Risks to people's health, safety and welfare was assessed, managed and monitored. Where we found missing associated risk assessment regarding nutrition, the senior carer assured us this would be addressed. Care plans provided guidance for staff to follow to meet people's needs.

The garden room was used by people as they liked to listen to the sounds of the outdoors and birds.

Ongoing refurbishment of the home, décor and new en-suite bedrooms. Further improvements to the adaptations could improve people's sense of wellbeing with clear signage to access different areas of the home. There was no contrasting colours used to distinguish the handrails from the wall. The outdoor paved area was used by people.

People were provided with enough to eat and drink. People's dietary needs were mostly met to ensure risks were managed and to maintain good health. People's health care needs were met, and they had access to a wide range of healthcare support. Procedures were followed to ensure people had the opportunity to express their wishes in relation to end of life care.

People were mostly supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

The activities coordinator with the support of the provider had improved the range of activities offered to people. They included group and individual activities and a selection of games, puzzles and books but not always age appropriate. People's relatives and friends were welcome to visit anytime. The service had maintained links with the wider community.

People had opportunities to express their views about the service through surveys and more recently the 'residents' meetings. People and their relatives knew how to make a complaint and were confident to speak with the care staff and the provider.

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

Rating at last inspection.
The last rating for this service was requires improvement (published 17 January 2019). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

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

We have found evidence the provider needs to make improvements as two breaches were found in relation to people's safety and quality assurance systems to monitor the care, environmental risks and the effectiveness of audits. Please see in Safe, Effective, Caring, Responsive and Well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Broomfield Residential Care on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to people's safety and the provider's quality monitoring systems and processes 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

We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not well-led.

Details are in our well-led findings below.

Broomfield Residential Care

Detailed findings

Background to this inspection

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

Inspection team
This inspection was carried out by two inspectors, a specialist nurse advisor and an Expert by Experience. The specialist nurse advisor had experience of working and caring for people living with dementia. The Expert by Experience had personal experience of caring for someone living with dementia.

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

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

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. This included notifications about significant incidents and the provider's action plan. We sought feedback from the local authority who work with the service and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our

inspection and made the judgements in this report.

During the inspection
We spoke with nine people who used the service and four relatives about their experience of the care provided. We spoke with a visiting community nurse. 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 10 members of staff including the provider, registered manager, team leader, senior care worker, care workers, the activity coordinator, the cook, domestic staff and the maintenance staff. The provider was responsible for supervising the registered manager of the service.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at two 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.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training information and some records relating to how the service monitors the quality of care and safety. We asked the registered manager to send information relating to staff training, their continuous improvement plan and the outcome and actions taken to the concerns raised. This information was received later than requested.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Preventing and controlling infection; Using medicines safely;

● At the last inspection there were concerns about the cleanliness. At this inspection similar issues were found. Infection control and prevention procedures were not always followed. Bedrooms were not cleaned properly. Bedrooms had built up dust, and stained furniture, bedding and dried spillages. Gaps in the skirting boards were dirty were difficult to clean. Dried food stains were found on the dining room walls and food trolleys. A communal bathroom was used to store equipment used to move people and a mop standing in a bucket full of dirty water. These items were removed but used later to clean the dining room floor. Foods such as jam jars were not dated when opened to enable staff to monitor food was safe to eat.

● Pressure relieving equipment such as the honeycomb foam pads used had no protective covers and were stained and damaged. They were not labelled with the person's name, which increased the risk of them being shared with other people. The provider had replaced all the pressure relieving mattresses but there was no system to routinely check for any damages and contamination risks. These checks were not included in the home equipment audits and checks.

● A staff member told us, "Some staff do not appear to understand the use of gloves only thinking they are used to protect themselves." We observed this to be the case despite disposable protective equipment being readily available and information about good hand hygiene practices.

● Domestic staff followed the cleaning schedules which included deep cleaning of bedrooms. However, the issues we found had not been identified by the registered manager when they carried out daily round checks.

● Medicines were stored securely but the clinic rooms were not secure. The door to one clinic room was left open despite having automatic closure and a secure access key pad. The other clinic area was an open walkway. People were seen walking freely through this area where sharp items such as scissors were easily accessible to all. This was raised with the registered manager and the provider.

● People received their medicines at the right time. However, a person said, "I'm given my medication on a plastic shovel type spoon, it can sometimes be a bit sharp on my lips, but I'm always given a drink afterwards. They don't always tell me what it is I am taking." A relative told us the tablet casing and powdery residue was left on their family member's lips. We also observed this to be the case. This showed care was not always taken when medicines were administered.

This evidence demonstrates a breach of Regulation 12 (g) (h) Safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because people's safety was put at risk in relation to infection control and prevention practices and the administration of medicines.

● Medicines were administered by trained staff who knew what to do in the event of a medicine error. We

observed a staff member administered medicines individually to people and completed the electronic medicines records to confirm medicines were taken.
● The electronic medicines administration system had safety features to ensure medicines were administered within the prescribed times and intervals. The system kept a track of stock levels and alerted the management team about errors and incomplete administration process.

Staffing and recruitment
● At the last inspection there were not sufficient numbers of staff to provide timely support to meet people's needs safely. At this inspection we found the provider made improvements. People's dependency needs had been assessed and the staffing numbers had been increased during the day from six to eight care staff. This meant there was a senior care worker and three care workers in each wing of the service. The provider had recruited an activity coordinator and they were in the process of recruiting a deputy manager to support the registered manager.
● There were mixed views about the staffing numbers. People who required minimal support said expressed no concerns. However, one person said, "They [night staff] have to hurry, and I am rushed as their shift finishes at 8.30am and they need to get people dressed." Relatives told us staff were not around to help people seated in the lounge. A relative said, "I don't think there are enough staff I have walked through the lounge and there hasn't been any staff there so residents are unsupported. I think there should be more staff to go around and check on people in rooms. It also seems to be different staff at the weekends who aren't as good."
● Staff felt they were 'stretched' at times. A staff member said, "After a review of [person's] care plan they now need to be hoisted and no extra staff are provided." The provider told us they used had systems to monitor the deployment of staff based on people's dependency needs. However, monitoring was needed to ensure staffing levels remained appropriate at busy times to maintain the safety of people and staff.
● Staff continued to be recruited in a safe way. Records showed relevant pre-employment checks were carried out to ensure only staff with the right skills and experience were employed.

Systems and processes to safeguard people from the risk of abuse
● People told us they felt safe and would speak with the care staff or the provider if they had any concerns. They said, "We are all safe here as there are staff around" and "It's safe here as I'm surrounded by safety features [emergency call bell which they could use]." A relative said, "I think generally they look after my [family member] well so [they] are safe here."
● Staff understood their responsibilities to protect people from abuse. They knew how to recognise the signs of abuse and who to report this to. A staff member said, "I am aware we can contact CQC and whistle blow."
● Records showed the provider had reported safeguarding concerns to the relevant agencies, investigated concerns and action was taken when required.

Assessing risk, safety monitoring and management
● Risks associated with people's physical and mental wellbeing were mostly assessed and managed. For example, people with swallowing difficulties, falling and moving around had been assessed. Care plans provided guidance so that staff knew what to do to reduce risk. Care plan for a person with a skin condition had no related risk assessments regarding their nutrition and hydration (which could increase the risk of developing a pressure sore, if not sufficiently monitored). This was raised with the senior carer to address. Records showed risks were reviewed monthly or when people's needs changed, and care plans were updated as needed.
● Further action was needed to ensure the environment was safe. There was no distinctive markings to alert people to the full-length fitted glass door panel. The pathway from the patio doors was not clear from

obstructions, and the sloped pebbled garden area presented further potential risks for people at risk of falls.
● Staff were trained in the safe moving and handling of people. We observed staff using mobility equipment in a safe way.
● Equipment within the home was regularly services and maintained. Evacuation plans were in place to ensure people and staff knew how to leave the premises safely in an emergency.

Learning lessons when things go wrong
● All reported incidents and accidents were audited monthly to identify any re-occurrences or trends, so action could be taken. For example, people at risk of falls were referred to the falls clinic. Moving and handling equipment was purchased to meet people's specific mobility needs.
● The provider took action when things went wrong and shared learning with the staff. For example, the guidance was updated to ensure staff followed the incident reporting procedures.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

● Further improvements to the adaptations and design of the home was needed to benefit people living with conditions such as dementia and visual impairment. The provider had worked with dementia experts to create a dementia friendly. However, the signage was not clear to enable people to freely access different areas of the home and to locate their bedrooms. Contrasting colours had not been considered to clearly distinguish handrails from the wall. People were not been involved in choosing the contents of the memory boxes. The symbols on the bedroom door had no relevance to the people who occupied the rooms.

● The garden room in the extension had outdoor sounds of birds, a green lawn effect carpet, conservatory furniture and plastic foliage. The outdoor paved area was used by people and staff as a smoking area. The outdoor paved area was used by people on warmer days. This area and access could be improved to ensure it remains accessible to all.

Staff support: induction, training, skills and experience

● Staff views regarding the induction and training was mixed. One staff member said, "It was not a proper induction and consisted of two weeks shadowing a senior or team leader."

● Training records showed staff had received training for their roles. The training covered personal care, oral hygiene and topics related to health and safety. Specialist training in areas such as dementia, challenging behaviour, equality and diversity was provided, and staff completed a workbook. However, staff practices were not formally checked by the registered manager to ensure people's needs were met in an effective and timely way.

● Staff said they did not feel well supported by the registered manager and found the supervisions were not productive. The frequency of staff supervision meetings had varied. In order to improve this, staff had been supervised by the registered manager, the provider and a team leader to ensure supervisions were up to date.

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

● People's needs were assessed before they moved to the service. This process ensured staff had the skills required and equipment was in place to meet people's needs. A relative told us the registered manager had assessed their family member's needs and any likes and dislikes regarding food and hobbies had been identified.

● The assessments were reflective of the current guidance and best practice standards. They considered people's individual needs, culture, age and disability so staff could meet these. Information about people's health conditions such as physical disability, dementia and sensory impairment had been documented and

described the support people needed.
● Assessed needs were reviewed monthly or sooner if people's needs changed and their care plans were updated as required. Staff showed awareness of people's needs and confirmed they had read people's care plans.

Supporting people to eat and drink enough to maintain a balanced diet
● People had mixed views about the quality of food and drinks. They said, "I've no complaints. I'm diabetic and have to have special food. I like it when the chef does their own sponges with lemon, but I'm not sure if that is diabetic food or not?" And, "The food is okay but it's not always warm." A relative said, "[Person] has to have pureed food, it's quite good, the food is put on the plate separately, so it looks a bit more attractive rather than in mixed together."
● People were offered hot and cold drinks. The cold drinks dispensers in the communal lounges meant people and visitors could help themselves to drinks.
● The meals were fresh frozen [prepared externally] and heated on site. The meals were well presented with a choice of seasonal vegetables. Staff supported people in a sensitive and appropriate way, they offered encouragement and gave people the time they required to eat.
● People were assessed for their risks of malnutrition and dehydration. Care plans had information about the support people to eat and drink. People at risk of choking were provided with foods that were suitable in texture.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People had access to healthcare services and attended routine health checks with the GP, optician and dentist. People's hearing aids were cleaned, and the batteries were changed fortnightly to prevent communication barriers. People had been referred to specialist services such as the falls clinic for further support and advice.
● Staff knew how to recognise changes to people's health and sought advice from appropriate healthcare professionals. For example, staff had attended training on pressure care prevention and made referrals to the community nurse when there was a concern with someone's skin condition.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).
● People had their capacity assessed and best interest decisions were made where this was required. Any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
● Staff had received training and understood their responsibility to ensure consent was sought in line with the principles of the MCA and DoLS.
● We saw staff sought people's consent, but people told us this was not always the case. One person said, "They don't always ask for my consent when they are with me. When I get up in the morning they take off my [night clothes] and I hear the sink being filled with water for my wash." This feedback was shared with the

provider to address.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. Requires improvement: This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

● People had mixed experiences about their involvement in day to day decisions made about their care. For example, one person said, "I ask if I could have a shower and they [staff] said they would give me one the following morning." Another person said, "I haven't had a bath or shower since I've been here. They give me a wash, as a bath would be too much of a problem."

● People were not actively encouraged to be involved in planning their care and reviewing their care plan. One person said, "It is men who help me with my bath as they have to turn the [bath hoist] around. I wasn't asked if I was happy with a man doing this." Preferences as to the gender of staff to support people with personal hygiene needs were not identified or documented in the care plan. This would enable staff to provide support in the way people preferred.

● We saw staff offered people choices as to how they wish to spend their time and respected wishes if people wish to remain in their room.

Respecting and promoting people's privacy, dignity and independence

● People continued to have mixed views and experiences in relation to how staff promoted and respected their privacy and dignity. One person told us staff had compromised their dignity and said, "I felt rushed as I was being undressed whilst sitting on the toilet."

● People's bedrooms were not respected as their own private space. We saw some staff and the registered manager entered people's bedrooms without knocking. This surprised one person in the room. For example, the domestic staff entered their room without knocking and said "Sorry, I've got to clean your room." This was share with the provider and they said action would be taken.

● People felt some staff were friendly. Staff gave clear directions to enable people to move around the home independently. A relative said, "I do feel better about [name] being here, as their appearance is better and [they] haven't had the infections [they] used to get."

● People's information was stored securely. The electronic care plans were passworded to ensure only care staff with the appropriate authority could access the relevant information.

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

● We saw staff treated people with kindness. A relative said, "Most of the staff here are quite caring; staff will come to [their] room and sing to [them] or play a CD. They chat to [person] when they are giving [them] a bed bath to try and distract them as [person] isn't keen on having one."

● Interactions between people and care staff was respectful. For example, a staff member was attentive and engaged in meaningful conversations with people whilst they painted their nails. Another staff member described the plated meal, the temperature of the food and their cutlery so the person could eat

independently. They encouraged the person to eat by keeping their interest through conversation and gave plenty of time to finish each mouthful.

● Staff knew people well. They knew how to offer reassurance and recognised when people were distressed or in pain even when people could not verbally communicate this.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. 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

● Staff were not always attentive or responsive to people's needs. For example, a person was supported by staff to have a cigarette outside but had not considered the need to wear a coat as it was cold outside. At lunch time there was not enough space for people to eat at the dining table so one person had their plated meal placed on the coffee table beside them. The meals were not served at the same time to people seated at the same dining. Classical music played over lunch until a staff member decided to change the music without seeking people's opinions about the music.

● Not everyone we spoke with felt they had control or choice as to how they needs were met. One person said, "Sometimes I ask staff to take me to my room and they ask me what I want from there. Sometimes I just want to spend some quiet time in my room as some people are a bit argumentative. Staff don't seem to like us staying in our rooms for a few hours." Another person felt they were treated "like children," and had to be supervised.

● Information in people's care plans varied. Some care plans reflected people's physical and mental needs and interests, whilst others had basic information about their care needs, daily routines, and about their early life, religious needs and things that were important to them. Records showed staff met people's specific needs such as re-positioning a person in bed at regular intervals to prevent them from developing pressure sores.

● Staff we spoke with knew people well and ensured people were not discriminated against even when verbal communication was difficult. Relatives were kept informed about any changes to their family member's needs, fluctuations in health and incidents. A relative said, "I am involved with [person] care plan, it is shortly being reviewed and I liaise with [staff] over this, [staff] is always on the ball over this and will phone me if there is any change."

Improving care quality in response to complaints or concerns

● People and their relatives were not confident to complain to the registered manager. One person said, "I wouldn't like to raise things with [registered manager] but I am happy to talk to [staff]." Another person said, "I can't fault the care apart from my missing clothes and watch." With permission we shared the concerns with the registered manager, who was not aware of the missing items. They did not follow the provider's complaints procedure. This was observed by provider and they assured us the complaint would be investigated in line with the complaint procedure.

● Records showed complaints documented had been investigated and action had been taken when required in a timely manner.

Meeting people's communication needs

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

● People's assessments and care plans identified any specific communication needs. Staff ensured people wore their glasses or hearing aids to reduce communication barriers. Staff faced people when they spoke to them, so they could understand and had time to reply.

● Information was available in accessible formats such as large print and easy read.

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 told us their visitors were made welcome. They gave examples of how they were encouraged by staff to maintain important relationships with family, friends and members from the community and the church.

● The activity co-ordinator encouraged people to take part in activities. They felt supported by the provider and had develop activities and invested in a range of books, games and sensory items although not all were age appropriate or suitable for people living with dementia or sensory impairment.

● The activity poster showed external visitor events but there was nothing displayed about the activities planned for each day. The activities coordinator hosted a sing-a-long with musical instruments in each of the communal lounge. Individual activities included reading to people, some people enjoyed having a manicure and their nails painted in their choice of colour.

● One person said, "I join in the activities, every morning we have 'shake and awake'. We sing songs and play musical instruments in groups. I can't use my talking book though as the ordered [electrical] leads still haven't come." Other people said, "It's my choice to stay in my room so I don't join in activities." And, "I'm not sure if there are activities for me to do I like to walk around." ● Relatives felt activities offered to people had improved. A relative said, "Staff have hobbies listed [in the care plan] but haven't acted on them. I bought an expensive jigsaw that is age appropriate and especially for people with dementia. I wish they had more things like that."

End of life care and support

● No end of life care was being delivered at the time of inspection.

● People's end of life wishes were explored and recorded. When people had made advanced decisions about their care, this was clearly recorded in their care plans.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. Requires improvement: This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

- At our last inspection the provider's quality assurance system was not used effectively and had failed to identify shortfalls. Care plans were not kept up to date to mitigate risks to people. There was no system to ensure staff felt supported and were encouraged to raise concerns and make suggestions.
- At this inspection not enough improvement had been made and sustained, and the provider was still in breach of regulation. Audits and checks had not picked up shortfalls and no evidence of the actions taken. For example, the medicine audit carried out in December 2019 by the registered manager stated there were no 'controlled medicines' (requires strict storage, recording and administration). This was incorrect despite being on the controlled drugs register. The registered manager was not aware of the need to check these medicines as part of the medicines audit. This showed they had not kept their knowledge up to date in relation to legal requirements relating to medicines management.
- Prescribed thickeners used to prepare drinks suitable for people with swallowing difficulties were found on an open shelf in the dining area and easy to access for people. Checks were not carried out to ensure equipment such as pressure relieving cushions were clean and safe to use. We saw unlocked storage areas where cleaning products and equipment was stored. The issues we found in relation to hygiene, cleanliness and environmental risks were not identified through audits and visual checks.
- Care plans had been updated and staff could access information on the electronic devices which were installed around the home. The information about people varied. For example they were not fully reflective of people's individual care needs, daily routines and how their health condition impacted on the support needed and information about their interests and hobbies.
- Staff felt they were not always supported or listened to. They told us supervisions were not productive or supportive. A staff member said, "During the last team meeting it was suggested to introduce employer of the month however no further action has been taken." Staff completed e-learning and booklets marked by the external training provider. Despite the staff supervision document used to encourage and advise staff, there was no other system such as observations used to check staff understood the learning because we saw staff had not put the learning into practice.
- The culture within the service could be more inclusive or empowering. Not all staff felt confident to raise concerns with the registered manager. The comments received included, "The registered manager's manner

is not very good, it is not pleasant. I wouldn't like to raise things with him, but I am happy to talk to [staff]." And "I don't think the home is well run. The care is quite good, but we don't get told of things that are happening for example the building work." The provider later informed us staff meetings were used to inform staff about the refurbishment plans and progress.

● The registered manager did not understand fully their responsibility in line with the duty of candour. Whilst they welcomed feedback on the day they did not appear to understand the relevance of involving people, their families and staff in decisions made about the home improvements, care provided and activities and suggested we speak to the provider. The provider told us they people, their relatives and professionals have access to their contact details and would meet with them when needed for instance to discuss any issues.

This evidence demonstrates a continued breach of Regulation 17 Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, for failure to ensure quality monitoring systems were used fully embedded and sustained improvements and for people and staff to influence changes to improve the service.

● The provider carried out visits to monitor the quality of care, the progress of refurbishment and to support the registered manager. An unannounced night checks were carried by the provider and the registered manager and action was taken to address shortfalls found regarding staff deployment, care delivered and completion of records.

● The provider had re-started the 'resident' meetings. Not everyone we spoke with could recall what had been discussed. The meeting minutes showed people welcomed the information and the newsletter produced. A relative said, "There is an open surgery on Friday mornings." However, no one attended these surgeries.

● The provider's policies, procedures, and the business continuity plan had been updated. This ensured the service delivery would not be interrupted by unforeseen events.

●The provider had notified the CQC of significant events they were required to by law and had displayed the previous rating within the home and on the provider's website, as required.

Working in partnership with others

● Healthwatch visited the service in March 2019 and made a number of recommendations in relation to the social engagement and activities, staff interactions, premises and meal time experience. We found some improvements had been made. For example, the range of activities offered to people and improved seating layout in the lounge to encourage interaction and conversation. Healthwatch plan to conduct a follow-up visit to check on the improvements made.

● The registered manager worked in partnership with key professionals such as community nurses. Commissioners told us the provider had made improvements in relation to the range of activities people could take part in and the staffing levels.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The provider told us they involved people and their relatives for 'food tasting' sessions to inform the new menus. There were drink stations created so people to help themselves to water or cordial. People had access to more fresh fruit, such as punnets of grapes and bananas.

● The service had developed links with the local community. The public were invited to coffee mornings and children from a local nursery visited during the festivities.

● Electronic and paper surveys were used to gather feedback about the quality of care. These were mostly positive and individual issues had been addressed by the provider.

● Staff told us the provider was visible and approachable and the communication was much improved. This included the staff handover meetings and system to check staff had read the information.

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 12 HSCA RA Regulations 2014 Safe care and treatment People's safety was put at risk in relation to environmental risks, infection control practices and the administration of medicines. Regulation 12 (g) (h)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure the systems to monitor quality and safety to were fully embedded, improvements were sustained, and people and staff were not fully involved to influence changes to improve the service. Regulation 17

The enforcement action we took:

We issued a Warning Notice against the Provider.