Berengrove Limited

Berengrove Park Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Berengrove Park Nursing Home is a residential care home providing personal and nursing care to 28 people aged 65 and over at the time of our inspection. The service can support up to 39 people in one adapted building.

People's experience of using this service and what we found
It is a condition of the provider's registration to have a registered manager in place. There was no registered manager, and it was unclear who was monitoring the quality of the service. There continued to be widespread shortfalls in the way the service was led as the provider did not have full oversight of the service.

Risk to people's health, safety and welfare were not consistently assessed, identified and monitored. Records were inconsistent and varied in the level of detail provided to guide staff to keep people safe.

The provider failed to ensure systems were in place to regularly assess and monitor the quality and safety of the service. Quality assurance audits were not undertaken regularly, and incidents and accidents were inconsistently recorded and monitored.

People did not always receive personal care as outlined in their care plans. Some people's care plans stated two staff were required to support personal care, during the inspection this was not taking place as outlined, with only one staff member supporting people. This placed people at risk and impacted on their dignity.

People were at risk of isolation. Most people were being cared for in their rooms with limited meaningful engagement between staff and people to mitigate this. Some activities took place in the lounge with minimal participation.

The provider had failed to act on a previous recommendation to make dementia friendly improvements to the building.

The service had failed to protect people's privacy and dignity.

Staff were not always deployed to provide support for people when they needed it. This posed risks to people and limited people's ability to interact with staff and other people.

The service had made improvements to care planning, however, they contained inconsistences which could lead to people's needs not being met and increased risk.

There were not enough skilled and competent staff deployed appropriately to meet people's needs. Some staff had not received suitable training to carry out their role.

People were 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.

People living at the service and their relatives said the service was caring. One person told us, "They [staff] look after me. My room is set up well, I have my TV, a fridge and have my meals delivered." A relative told us, "The nurses interact with my [relative] in a nice way and ask courteous questions".

Medicines were safely managed and administered. The provider had made improvements since our last inspection and medicines were stored correctly and dispensed at prescribed times. Medicine administration records were correct, and audits took place to highlight any errors.

Infection Prevention and Control policies and procedures were being followed. The premises looked clean and tidy and we were assured that the service had controls in place to minimise the risks posed by COVID-19.

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

Rating at last inspection and update
The last rating for this service was requires improvement [published 03 September 2019] and there were multiple breaches of regulation. 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/sustained, and the provider was still in breach of regulations.

The service has deteriorated to inadequate. This service had been rated requires improvement for the last five consecutive inspections.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection. We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements in all areas. 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 previous comprehensive inspection, by selecting the 'all reports' link for Berengrove Park Residential Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to assessing and monitoring risk, staffing, accident and incident recording and auditing, person centred care, dementia friendly adaptations, dignity and good governance at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Berengrove Park Nursing Home

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was carried out by two inspectors.

Service and service type
Berengrove Park Residential Home 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.

At the time of our inspection the service had a manager registered with the Care Quality Commission. However, they were no longer working as the manager and have subsequently deregistered. A registered manager 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. We sought feedback from the local authority. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with three people who used the service and four relatives about their experience of the care provided. We spoke with nine members of staff including, four nurses', a care team leader, two care assistants, a cleaner and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We reviewed a range of records. This included four people's care records, accident and incident 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 data, staffing rotas and COVID-19 procedures and visiting protocols.

Inadequate

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 now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management
At our last inspection the provider had failed to ensure people received care that was safe. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

• Risk assessments and care plans did not identify all areas of risk and provide guidance to staff about what to do should that risk occur. One person was identified as having epilepsy, with no care plan or risk assessment in place to manage this. No guidance was in place for staff to follow if the person had a seizure or how to administer the associated medicine.
• Care plans contained a lack of detailed information which left people at risk of receiving the wrong support. For example, one person's care plan identified a risk of choking. The plan described needing a pureed diet and subsequently mentioned fortified meals and 'safe snacks', with no reference to what safe meant. The person also had a SALT [Speech and Language Therapy] review which recommended a different diet which was discounted by a nurse, without a further SALT review documented. There was a risk that the person would be placed at harm by staff not following SALT recommendations and unclear guidance.
• Risk to people's health, safety and welfare were not consistently assessed, identified and monitored. For example, people's care plans stated for staff to check identified risks 'every 1-2 hour's'. They did not state what staff should be checking for, or actions required to minimise risk. Staff had completed daily records to show they had visited people at the desired frequency but did not provide any detail about what was checked, and any actions taken.

Systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Firefighting and support equipment was safe. Checks were performed by competent persons at regular frequencies to ensure equipment was effective and safe.

Staffing and recruitment
At our last inspection we recommended the provider seek advice from a reputable source to review the allocation of staff throughout the day to ensure people receive support when they need it. The provider

failed to do this.

• There were not enough skilled and competent staff deployed appropriately to meet people's needs. We observed people requiring support left alone at lunch times, one person being left alone whilst being sick and subsequently requiring paramedic assistance and a single member of staff performing personal care, when the person's care plan stated two staff members were required. This led to people being left at increased risk of harm and did not meet their identified support needs.
• The provider did not have a system in place to determine safe staffing levels, and to ensure there were sufficient, competent and skilled staff on duty to meet people's assessed needs.

Systems were not in place or robust enough to demonstrate enough staff were deployed appropriately to meet people's needs. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Staff were recruited safely. Disclosure and Barring Service checks had been completed before new staff members started their employment. This helped prevent unsuitable staff from working with people.
• Nurses were registered with the Nursing and Midwifery Council and checks were completed to make sure their registrations remained valid.
• Application forms had been completed by new staff with any gaps in employment explored. References were checked and records kept.

Learning lessons when things go wrong
• The provider did not have effective processes in place to monitor and review incidents and accidents. This placed people at risk from incident reoccurrence.
• Not all incidents and accidents had been recorded and some were not reviewed to ensure that trends could be identified, and risks mitigated. For example, one person had an unwitnessed fall, but no detail was included about the injury or what happened next. The same person had a further fall in the same month and no further action was recorded.
• Staff were not aware of where to record incidents. When we reviewed these, we were given an incident book, after probing we were given another. One nurse said they had not seen the second book before. Both incident books contained details of different incidents and limited details of actions taken to minimise risk reoccurrence.
• Accident and Incident audits did not identify that staff were recording incidents in different places and incidents recorded did not provide a detailed summary of the incident and actions taken to prevent further harm. The provider did not have a robust system in place to learn from themes.

Systems were either not in place or robust enough to demonstrate the provider was learning lessons when things go wrong. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
• We identified gaps in risk assessments and incident reporting. We have also identified poor staff knowledge of procedures and management oversight in these areas. Therefore, we cannot be assured that robust procedures are in place to safeguard people from abuse.
• We identified people being supported in a way which differed from their care plans and this had not been identified or corrected by management.
• Staff had received up-to date training in safeguarding adults. This provided staff with an understanding of the different types of abuse and what to do if they suspect abuse.
• Staff said they were able to highlight safeguarding issues to senior members of staff. One member of staff

told us, "I can approach any of the nurses or seniors, they do listen to you"; another said, "I am able to speak to the manager or any of the nurses".
• The nominated individual said they knew how to report concerns to the Care Quality Commission [CQC] and local safeguarding authority.

Using medicines safely
At our last inspection the provider had failed to ensure consistent safe management of medicines. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12 with regard to medicines.

• Medicines were managed safely. The service had made improvements to their medicines audit procedure. An allocated nurse performed regular medicines audits to ensure that medicines were being administered safely. If any shortfalls were identified, then action was taken to address issues and prevent re-occurrence.
• Improvements had been made to medicine dispensing records, to ensure they were completed properly. Medicine administration records were accurate and stock numbers recorded. We looked at several specific medicines and all tallied with medicine administration records.
• Medicines were being administered at the correct time and as prescribed. Nurses administering medicines had received training and we observed medicines were dispensed in a safe way. A nurse told us that all nurses had received additional in-house medicines training by another nurse and training records corroborated this.
• Medicines were stored safely in a clean medicines room in a trolley which was secured to the wall when not in use. Regular temperature checks were being performed to ensure medication effectiveness.
• Medicines subject to specific storage measures were stored and administered safely. The administration records were complete, and the totals in stock tallied with the records.

Preventing and controlling infection
• We were assured that the provider was preventing visitors from catching and spreading infections.
• We were assured that the provider was meeting shielding and social distancing rules.
• We were assured that the provider was admitting people safely to the service.
• We were assured that the provider was using PPE effectively and safely.
• We were assured that the provider was accessing testing for people using the service and staff.
• We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
• We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
• We were assured that the provider's infection prevention and control policy was up to date.
• We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

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.

Staff support: induction, training, skills and experience
At the last inspection the provider failed to ensure staff received the training and development required to provide people with the care and support they needed. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was in continued breach of regulation 18.

• Nurses did not receive any clinical supervision. Following the last inspection, the provider wrote to CQC with an action plan and noted that nurses would receive clinical supervision. Clinical supervision has been linked to good clinical governance, by helping to support quality improvement, managing risks, and by increasing accountability. The provider failed to do this.
• Staff had not all received suitable training to carry out their role. We identified training gaps in epilepsy, falls prevention and choking. We reviewed the training matrix and found no staff had received training in choking; several nurses and care staff had received no training in epilepsy and only two nurses had received training in falls prevention. These are areas we identified as a risk to some people living at the service and a lack of staff competence in these areas' placed people at increased risk of harm.

Systems were not in place ensure staff received the training and development required to provide people with the care and support they needed. This placed people at risk of harm. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Nurses supported each other by providing training to each other on specific areas, such as medicines administration. One nurse told us, "I am a trained assessor in medicines and train the other nurses".
• Staff completed an induction when they began working at the service. New staff completed the Care Certificate. This is an identified set of standards that social care workers adhere to in their daily working life.
• Staff received regular supervision by a line manager. One to one meeting's were held to discuss their personal development and well-being.

Adapting service, design, decoration to meet people's needs
At the last inspection we recommend the provider seek guidance from a reputable source about how to support and empower people living with dementia. Whilst the provider had made some dementia friendly adaptations and design decisions to a new wing of the building, the provider had failed to make any

improvements to the older parts of the building, where most people lived.

• Noticeboards were not used to communicate messages to people living at the service. Notices in communal residential areas contained staff information of no relevance to people living at the service and some notices were old and frayed. This did not provide a homely environment for people.
• Adaptations, such as signage, colour coded doors and frames were not used to easily direct people living with dementia to where they wanted to go. One person was wandering the floor asking where the toilet was. Adaptations of this nature may support people living with dementia to feel more comfortable and promote independence.
• Communal areas, such as the main lounge and corridors, were not homely and looked tired. One lounge which was adapted for Covid-19 testing, had boxes stored and staff personal items contained within.

Systems were not in place to identify and provide suitable adaptations to meet people's needs. This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People's rooms were personalised and contained items important to them.

Supporting people to eat and drink enough to maintain a balanced diet
• Care plans contained contradictory nutritional information. For example, one person's care plan said staff should 'offer high calorie snacks between meals' & continue to fortify meals', and in another part of the care plan it states the person should have a liquidised diet. This could pose a risk to people and failed to guide staff how best to support people to achieve a balanced diet.
• People experiencing regular physical difficulties with their eating/drinking had been referred to health care professionals. Their recommendations were recorded in people's care plans. However, we did notice an inconsistency between one person's SALT recommendation and the guidance staff were following in their care plan. This could place the person at risk, no further referral or discussion with SALT was recorded.

This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People were supported to maintain a healthy weight. Staff monitored people's weight and contacted health care professionals, when they were concerned about an increase or loss of weight. People were provided with fortified meals and drinks when required.
• People were offered choices of hot and cold drinks throughout the day. Fluid plans and charts were recorded in people's care plans.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's needs were assessed, however, some contained contradictory and/or a lack of detailed information which left people at risk of receiving the wrong support and care.
• The service did not use accessible communication methods to ensure that people with communication needs had their choices considered in their care plans.
• People's needs were assessed before they began living at the service to make sure their needs could be met.
• Care plans included consideration of people's physical, mental, cultural and well-being needs.
• Staff had received training and demonstrated knowledge to deliver care in line with standards, guidance and the law.

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

At our last inspection the provider failed to demonstrate that people's rights had been considered according to the basic principles of the Mental Capacity Act 2005. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 11.

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]. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

• People's mental capacity to make specific decisions were assessed and recorded in people's care plans. When people were unable to make decisions for themselves, staff met with relatives to make a decision in the person's best interest.
• Evidence that the relatives were legally able to make those decisions, such as Lasting Power of Attorney [LPoA], were recorded. LPoA gives someone the legal right to make decisions about a person's care and treatment when they are no longer able to do so themselves. One relative told us, "I trust the staff to make decisions in mums' best interest".
• Staff had received training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support;
• Staff communicated with and made referrals to health care professionals. Staff were observed communicating with a GP during our inspection.

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. 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
• The service did not always identify and employ suitable non-verbal communication methods, to communicate with people with communication needs or aid their decision making. For example one person's moving and handling care plan stated the person had a learning disability and "tends to say no or oh no to everything but compliant with whatever care given" and their cognition care plan stated "able to make day to day decisions". These plans did not identify how best to communicate with the person, given their limited communication, so they were able to express their views and be involved in decisions about their care.

Systems were either not in place or robust enough to demonstrate the service met people's needs and reflect their personal preferences. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Respecting and promoting people's privacy, dignity and independence
• We observed most people being cared for in their rooms. Interaction between staff and people was limited, despite some care plans detailing how people would like to be engaged.
• People were not supported to eat in a dignified or safe way. We observed people eating by leaning over bed rails and from their laps.
• People's care plans recorded who had been involved in developing the plan. There were records about how decisions were made if the person was not able to make their own decisions.
• Relatives said people were well cared for. One person said, their relative, "Seems to be happy here. [They] like it"; another told us, "There are no issues with care here".

Ensuring people are well treated and supported; respecting equality and diversity
• Staff knew people well, and their choices and preferences. One relative told us, "I think they do a really good job".
• People's beliefs and diversity was discussed, and people's wishes, and support needs had been recorded in 'spiritual and cultural' support plans.
• People were spoken to with kindness and compassion. One member of staff told us, "I really enjoy talking to the residents".

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. This meant people's needs were not always met.

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.

At our last inspection we recommended the provider seek guidance from a reputable source to improve the way information is communicated with people in a way they can understand. The provider had failed to make improvements.

• The provider had not ensured that information was available to people in ways they could understand, such as large print or pictures. Several people living at the service had communication needs and could be excluded from participation in their care.
• Care plans were not provided in an accessible format to help people make decisions about their care.
• Signage and notices were not displayed or available in an accessible format.

Systems were either not in place or robust enough to demonstrate the service met people's needs and reflect their personal preferences. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
• Care plans had limited detail to reduce social isolation. For example, one person's care plan mentions a risk of isolation as the person was cared for in bed. The plan stated for staff to 'check every 1-2 hours' but did not detail what staff should do or how they should interact with the person to reduce the risk of isolation.
• An activities person was employed and was observed interacting with some residents in the lounge. However, during our inspection we observed most people were cared for in their bedrooms, with limited social interaction. Staff were not deployed to engage people in their rooms to reduce their isolation.

Systems were either not in place or robust enough to demonstrate the service met people's needs and reflect their personal preferences. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The nominated individual told us they had arranged for several externally provided activities to take place in the service in the coming months, now that COVID-19 restrictions had been eased.

• People were supported to meet with their relatives. One person told us, "I look forward to my daughter visiting and going to the park for a picnic".

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
• Care plans contained contradictory information. For example, one person was identified as having a choking risk. The person had a 'swallow' and 'choking emergency' risk assessment in place. These documents contained different guidance on actions to be taken if the risk occurred. The person could be at increased risk if staff followed incorrect guidance.
• People were not provided with the support they needed. For example, one person's care plan said they liked cooking, knitting, sewing, gardening. There were no records for this person participating in these activities. Another person's care plan stated they were agitated by male staff; however, this was omitted from their challenging behaviour risk assessment, instead stating that people should always attend the person in pairs.

Systems were either not in place or robust enough to demonstrate the service met people's needs and reflect their personal preferences. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Care plans included an overview of the person, their needs and preferences. This contained details of the person's history, likes and dislikes and communication needs. Staff working at the service were able to reference these to understand how to support people.

Improving care quality in response to complaints or concerns
• People and their relatives told us they knew how to complain. A relative said, "I can raise concerns with the owner, [they] are always around".
• The provider had a complaints process which was followed by staff.
• Complaints, comments and concerns were dealt with appropriately and satisfactorily resolved. A relative told us, "They managed to get [my relatives] ulcer healed", when they highlighted their concern on referral.

End of life care and support
• People were supported to have a comfortable and dignified death.
• People's beliefs were discussed, and people's wishes, and support needs had been recorded in their end of life care plans and 'spiritual and cultural' support plans.
• People's end of life wishes were discussed. People, who chose to, had their wishes recorded in their care plans. These detailed the person's wishes as they neared the end of their life and funeral arrangements.
• Relatives with appropriate authority were involved in end of life care planning.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

At the last inspection the provider failed to ensure the systems were in place to regularly assess and monitor the quality and safety of the service. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of Regulation 17. This was the fifth consecutive inspection where a breach of Regulation 17 was identified. The overall rating and this key question has deteriorated to inadequate, the service had previously been rated Requires Improvement for five consecutive inspections. The provider has consistently failed to have adequate oversight of the service.

• Accident and incident reviews by management were not robust and consistently effective. For example, audits failed to highlight that some incidents had not been recorded in the incident book. The incident and accident book did not provide space for a detailed account of the incident, persons contacted, review and further actions for staff to take to keep people safe. The incident book used was designed to report staff accidents to the Health & Safety Executive [HSE], HSE is an independent regulator that aims to prevent work-related death, injury and ill health.
• Staff were not all aware where to record accidents and incidents. On our first day of inspection we were provided with an accident and incident book to review. On the second day of inspection we were given a different book. A member of staff told us they 'did not know the second book existed, until today'. We reviewed the incidents recorded in these books and they did not contain details of some incidents recorded in people's care plans. We could not be assured that all incidents were being recorded by staff and reviewed by management to prevent incident reoccurrence.
• People's care plans and the associated risk assessments contained conflicting information and/or did not provide detailed guidance for staff to take should risk occur. There was a risk staff may provide incorrect care and support to a person.
• When we inspected the service had a manager registered with the Care Quality Commission (CQC). However, this person was no longer working as the manager and said they 'did not realise they needed to deregister' and started the deregistration process during the inspection.
• Monthly quality assurance audits did not take place regularly. For example, the last 'environment' audit took place in April 2021 and the last IPC audit in April 2021. Regular audits allow management to assess and

monitor the quality of the service. The provider had not maintained enough oversight to ensure this took place and make the necessary improvements.

This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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
• The nominated individual said they understood their responsibility in relation to duty of candour. Duty of candour requires providers to be open about any incidents in which people were harmed or at risk of harm. However, we found that not all incidents and accidents were recorded and reviewed. Therefore, we could not be assured that the provider had taken action to disclose all incidents appropriately when people were harmed or at risk of harm.

This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• Management did not always communicate with staff in a way which promoted a positive culture. After the inspection we made a recommendation to change some wording on staff signage.
• People were not empowered to live independently. The provider failed to act on previous CQC recommendations to make adaptations to the building and accessible information to support people living with dementia.
• Management failed to effectively deploy staff to interact with people. During our inspection we observed a lack of meaningful interaction between people and staff. People were left alone in their rooms which does not promote a person-centred, inclusive and empowering outcomes for people living at the service.

This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People and their relatives knew the staff and provider and spoke positively about them. One relative told us, "I have always been received in a friendly way, the owner is very sensible and approachable".
• Staff said the culture of the service had improved. One member of staff told us, "Things are much more efficient now, orientated towards the residents and more person centred".

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics/ Working in partnership with others
• Staff worked with health care professionals, such as GPs, to provide joined-up care. During our inspection we observed nurses communicating with the GP about people's care and care plans updated with GP guidance.
• People's equality characteristics were recorded in people's care plans.
• Relatives were able to visit people as COVID-19 visiting guidance changed. The service has considered people's mobility needs to enable these visits to take place in settings appropriate for them.