Tamaris (Ram) Limited

Bracknell Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Bracknell Care Home is a care home providing personal and nursing care to a maximum of 30 older people some of whom may be living with dementia and/or physical disability. At the time of the inspection the service was supporting 25 people.

People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. The accommodation is arranged over two floors, with all rooms having en-suite toilet facilities and some also having an en-suite shower or bathroom. There is one large communal space that is divided into small areas. These include dining room, living space and activities area.

People's experience of using this service and what we found
The care and treatment of people was not always appropriate and did not always meet their specific needs. Care plans did not evidence that people were being involved to the maximum extent possible in their care or that their preferences were always being taken into consideration.

People were at risk of potential harm because the registered person had failed to ensure the proper and safe management of medicines.

People were at risk of potential harm because the registered person had not ensured the staff providing the care had the competence, skills or experience to do so safely. The registered person had not ensured staff were provided with appropriate support, training and knowledge as was necessary for them to do their job safely and effectively.Training records provided post inspection provided a snapshot of one week's compliance with differing provider mandatory training courses.

At the last inspection it was found that the registered provider had not made sure staff employed were of good character and that all required information and checks were carried out. This meant people were potentially at risk of staff being employed to work with them who were not suitable. At this inspection it was found that the provider had still failed to ensure people were supported by appropriate staff.

At the inspection of December 2018, the registered provider had not established an effective system to enable them to ensure compliance with their legal obligations and the regulations. They had not established an effective system to enable them to assess, monitor and improve the quality and safety of the service provided. The lack of robust quality assurance meant people were at risk of receiving poor quality care and, should a decline in standards occur, the provider's systems would potentially not pick up issues effectively. We found systems remained ineffective and issues remained prevalent in all areas of care.

People were not supported to have maximum choice and control of their lives and staff did not support

them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

A new registered manager had been appointed along with a new senior management team since the last inspection. They envisaged making changes to the service that would promote inclusivity, safe, effective and responsive care. However, this was yet to be actioned with sustainability to be achieved.

People had their healthcare needs identified and were able to access healthcare professionals such as the GP, optician when needed. The service worked well with other professionals to provide effective health care to people.

The service had recently commenced residents and relatives' meetings as well as staff meetings to ensure there was opportunity to receive feedback about the home.

The registered manager had created strong links with the community and had commenced developing a plan for people to engage in meaningful activities in 2020.

The service responded well to complaints, with clear evidence maintained of all investigations. The documents illustrated transparency, with actions identified where shortfalls were noted. Similarly, the registered manager understood how to comply with the duty of candour. Letters were transparent in their findings and offered the opportunity for further discussion.

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 18 December 2018) with breaches in regulations 9 (person centred care) and 17 (good governance). The provider completed an action plan after the last inspection to show what they would do and by when to improve.
At this inspection improvement had not been made and the provider was still in breach of these regulations.

Why we inspected
This was a planned inspection based on the previous rating. However, we had recently received a number of notifications that gave us cause for concern.

Enforcement
We have identified breaches in relation to regulations 9 (person centred care), 10 (dignity and respect), 11 (consent), 12 (safe care and treatment), 15 (premises and equipment), 17 (good governance), 18 (staffing), 19 (fit and proper persons employed) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 at this inspection. Care provided was not always person-centred; people did not always receive safe care and treatment and were not always protected from the risks of harm or abuse; staff recruitment, training and support were not adequate to ensure people were safe or that staff were competent and suitable for their roles, specifically around their understanding of capacity; effective systems were not in place to ensure the service met the required fundamental standards of care. The registered person had failed to ensure the premises were conducive to people's changing health needs.

We are mindful of the impact of 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.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and 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.

Special Measures
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 not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

For 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?

Inadequate

The service was not 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.

Bracknell Care Home

Detailed findings

Background to this inspection

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

Inspection team
This inspection was completed by one inspector on both 11 and 12 December 2019. A specialist pharmacy inspector was present for day one – 11 December 2019, to provide knowledge and guidance specifically around medicine management.

Service and service type
Bracknell Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as 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
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. Nevertheless, we focused on the notifications the service had forwarded to us. Notifications are to be sent to the Commission in events of safeguarding, serious

incidents, accidents, applications are under the MCA, and any other issues that are related to the operations of the service. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with five people who used the service and two relatives about their experience of the care provided. We spoke with eight members of staff including the regional manager, registered manager, supporting registered manager (from a sister service), two registered nurses, two care workers and one domestic. 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 reviewed a range of records. This included six people's care records and multiple medication records. We looked at five 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 and quality assurance records. We spoke with three professionals who regularly visit the service, and sent out surveys to staff.

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 good. At this inspection this key question has now been rated as inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

● People were not protected or kept safe by the use of appropriate medicine management. We found there was a number of concerns related to medicines management.

● One week prior to the inspection, the registered manager was made aware of a number of concerns related to unsafe medicines management, which was duly reported to the CQC. These incidents are currently being investigated, therefore this inspection did not examine this.

● We found that 'as required' medicine (PRN) guidance was not written for some of the people who required PRN medicines. This meant that staff were not provided with the necessary information on when to offer and administer these medicines. Guidance missing included, what signs to look for, what to try in the first instance and when administration should commence, including dose to give.This was brought to the attention of staff, who assured us guidance would be put in place by the end of the day.

● For another person we found information pertaining to what time medication was to be administered was missing from both the medicine administration record (MARs) and the medicine care plan. This is of specific concern as medication related to a specific medical condition the person had requires being given at a specific time to control the symptoms of the condition. This means if the medicine is not given at the right time they can feel significantly unwell. Symptoms can worsen overtime and the condition can mean the person's health can rapidly deteriorate.

● We also found that where PRN medication had changed to regular daily medicines (or vice versa), no information was recorded on who had authorised this and when. The deputy manager was unable to evidence that this had been agreed by a qualified medical practitioner.

● One person in the home was on controlled drugs. These are medicines that require storing more securely due to the use of these being regulated by the government. We found that we were able to access the secure cabinet as the keys had been left in the room, where the cabinet was secured. This meant that any staff who entered the room could have access to the controlled drugs.

We were not assured people would receive proper and safe management of medicines. This is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● On the observed medicine round, we saw that the registered nurse administered medicines safely, and signatures had been correctly recorded.

Assessing risk, safety monitoring and management

● People were not always protected from the risk of harm. Whilst we found that some risk assessments had been completed, we noted that any risks identified had not always been mitigated. The documented action

had not been taken. For example, one person, who was at high risk of falls, required their walking aid to be situated in close proximity to them so that they could use this to mobilise. On day one of the inspection we found the walking aid was placed six seats away. A sensor mat was also to be used to alert staff when the person was up and about. There was no sensor mat in place. The person was new to the service having only been in the provision for a few weeks. Whilst there had been no falls reported, the appropriate measures had not been taken to mitigate the risk, therefore the potential for a risk remained present.

● There were similar issues noted in another two files, where people were noted as being at high risk of falls, however appropriate measures had not been taken to prevent the risks from occurring.

● One person who had epilepsy did not have any risk assessments or care plans written to highlight to staff what action to take should the person have a seizure. This placed the person at potential risk of serious harm.

● The service employed a maintenance person to ensure the property and equipment was safe for use. We found that not all checks had been documented as completed. We further found that where recordings did not meet the minimum standard no action had been taken. For example, where water temperature was below or exceeding the required temperature no action had been taken to ensure prevention of legionella for over four months. The registered manager had requested the estate maintenance person to check the readings, however no date was available for when the check would be completed. There was no evidence of when the request had been submitted.

● Similarly, we found that where fire doors were checked routinely, one door that was noted to have issues had not been checked in over six months. All other doors were checked within the six-month timeframe at least twice. It was unclear why this door was not documented as having been checked, therefore the appropriate measures may not have taken to keep people safe. The door was one of two that led to the communal lounge. We spoke with the registered manager, administration staff and registered nurse regarding the door, all stated the door was "temperamental" in relation to opening and closing.

● Each bathroom in the service had a thermometer available for staff to take water temperatures before supporting people with personal care. However, we found that no records were maintained of the water temperatures. We spoke with the registered manager regarding this and were advised all records should be maintained in the bathrooms. This therefore meant the provider could not be assured that staff had taken water temperature recordings to ensure they were supporting people to have showers at a safe temperature.

This meant that we were not assured the provider had taken the necessary action to assess and mitigate risks to people. This is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service had a comprehensive business continuity plan in place. This detailed what course of action staff needed to take in the eventuality of an emergency. For example, in the event of no gas, no electricity, or a virus breakout.

● All people residing at the service are required to have an individualised personal emergency evacuation plan (PEEP). The PEEP is designed to inform staff on pertinent information related to a person's mobility, ability to follow instruction and formal diagnoses that may impact in an emergency evacuation process. The service had these located in each person's room. However, on day one of the inspection, we found that not all PEEPs were kept in people's room. By day two of the inspection, the registered manager had ensured this had been resolved.

Staffing and recruitment

● At the last inspection we found that the provider's recruitment processes did not enable the safe recruitment of staff. Following the inspection, we were assured that measures would be implemented to

ensure appropriate checks were completed prior to staff commencing employment. Audits would be carried out routinely.
● At this inspection we found that staff recruitment files had not been checked in line with guidance. We found that none of the files contained any photographic identification of staff. This was raised at the previous inspection. Similarly, gaps in employment were not verified, full employment histories were not obtained, nor were conduct checks where staff had previously worked in health and social care. For one staff member we noted their dates of previous employment did not match those obtained in their reference.

● We spoke with the registered manager regarding the recruitment files reviewed, specifically concerning these were the same issues raised at the previous inspection of 2018. We were told that all HR checks would be completed following this inspection.

The provider failed to establish and operate effective recruitment procedures to ensure staff suitability for their role. This is a breach of Regulation 19 (Fit and proper person's employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● During the inspection we found that there were insufficient staff present to keep people safe. For example, we found that on day one of the inspection one person requested assistance with the toilet at 13.29hrs. A member of the inspection team alerted staff. The member of staff in turn requested the person wait for two minutes. Assistance did not return until 13.45hrs.
● Similarly, we noted that people were left alone in the lounge area for lengthy periods of time without any engagement from staff, other than those walking through to the kitchen. On day one we found the activity co-ordinator spent time with one person out of eight who were in the lounge area. A volunteer sporadically spoke with another person. Six people were left disengaged and without any interaction or involvement from staff for over three hours. We spoke with the registered manager regarding the lack of staff presence specifically to determine if this was a staff deployment or employment issue. We were unable to establish what staff were doing during the three hours people were left without interaction. We were told many of the issues were related to shift planning.
● A volunteer, who has had no formal training (or has been assessed as competent by the provider) commenced supporting a person in moving and handling techniques, due to lack of staff presence. This presented a risk not only to the person being supported, but also other people sat in the lounge (one of whose foot was stepped on), as well as for themselves. We raised this with senior management present during day one of the inspection, who advised volunteers should not be involved in moving and handling.
● One person informed us of a situation where an altercation occurred between another person and a visiting relative over a weekend. They stated they physically intervened to prevent the situation from escalating, as no staff were present. It was unclear where staff were during the incident, and why people and their relatives had been left unattended. We sought clarification on this from the registered manager, who informed us this was indeed correct, and they had been informed of the incident. An investigation was currently underway.

This meant that we were not assured there were sufficient staff deployed or employed to keep people safe. This is a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● Electronic records were kept of all incidents and accidents, that were assessed both at home level and at provider level by the senior management team.

● Whilst feedback was given to the registered manager and management team we found that the necessary action to implement the required learning identified from accidents and near misses were not always taken. For example, we found that on day one of the inspection a person who was meant to have their walking aid and a sensor mat used at all times, was left without these. The registered manager was alerted to this by the inspection team to prevent a possible incident. On day two of the inspection, the person was again found in the communal area, without a walking aid and sensor mat. This therefore illustrated that lessons were not being learnt from potential near misses.

Systems and processes to safeguard people from the risk of abuse

● People were protected by systems and processes to protect them from the risk of abuse.

● Most staff had received training in safeguarding, that was refreshed annually. However, no staff had yet attended the Safeguarding of Vulnerable Adults training that was face to face. All incidents of potential and actual safeguarding were appropriately reported to the Care Quality Commission (CQC), with additional information provided as updates.

● We spoke with staff, all of whom reported they knew the procedures to report concerns. They were able to describe various forms of abuse, as well as the protocol to follow. Staff reported that they would whistle blow to the local authority safeguarding team or the CQC if they felt the provider had not acted upon their concerns.

Preventing and controlling infection

● We found the home was clean. There were no malodours in the bathrooms or the home generally, and the home looked well-kept and whilst well lived in.

● Staff training records indicated all staff were trained in the prevention and control of infections.

● Personal protective equipment was available for staff, such as disposable gloves and aprons to prevent the spread of infection. Colour coded mops and cleaning products were used to prevent the possibility of cross contamination by all domestic staff.

● The kitchens had been rated 4 out of 5 (good) from the FSA (Food Standards Agency). The FSA primary role is to ensure that services that serve or sell food, do so in line with hygiene standards. The rating of 'good' therefore illustrates an acceptable rating for cleanliness.

● Cleaning rotas were kept in each person's bedroom that domestic staff had to sign off when the room had been cleaned. Similarly, rotas were used for all communal areas. However, we found that these had not been maintained and signed off to indicate when the area had been cleaned. For example, in one month the record had not been signed for eight consecutive days. The registered manager assured us this was a documentation issue and that domestic staff were cleaning, however, not always signing the audit to record this.

Inadequate

Is the service effective?

Our findings

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

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

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

● The service prepared pre-admission assessments on potential new admittances. However, we found that these were not completed in their entirety. Often information pertinent to people's religion, sexuality, mental capacity was left incomplete. This meant that the service was not generating a full understanding on people's needs and establishing what was important to them from the onset of providing support.

● Care plans suggested they were formulated using information from the pre-assessment, as well as from people, relatives and professionals. It was unclear if relatives involved in care plan writing were consulted with people's agreement. We spoke with one person who reported they were unaware a care plan existed on them. We were told, "I do not recall ever be consulted or asked how I would like to be supported."

● Care plans were not person centred and failed to advise how the person wished to be supported. For example, we found that where a person was non-verbal the care plan did not provide or suggest ways to communicate with the person. This meant the service did not meet or establish the person's needs. The impact on this was significant. The person was unable to communicate their needs or wishes, and the service had failed to explore this. In another instance a person was labelled as a "fussy eater" within the care plan, as they preferred spicy food. We explored this with the registered manager, who advised meals tended to be traditional English meals, acknowledging that not everyone's meal preferences were met. This meant the person would often leave large quantities of their meal and had begun to lose weight. Whilst this was being managed through the implementation of a fortified diet, this was not the most appropriate method to use. By simply offering alternative food options the person's food intake would increase.

● Similarly care plans failed to explore and understand behaviours or mannerisms that people may exhibit as a result of their formal diagnoses. For example, a person with Parkinson's may walk more frequently, however experience problems with stability resulting in falls. Rather than supporting the person to walk as they wished, the focus was on the high risk of falls, with suggestions of how to prevent the person from walking rather than enabling and managing the risks associated with it. This created a restricted environment that was unsupportive to the person's changing needs.

● The provider had developed a new document that focused on establishing people's likes and dislikes, as well as gaining their social history. However, this was incomplete for most people within the service. The registered manager acknowledged the need for this to be completed urgently.

● We found only two staff from a team of 23 had attended training on care plan writing. This meant that all other care staff (17) who were expected to write care plans did not have the knowledge or training to understand what details to include when writing a plan of support. The registered manager advised this course was being booked as part of a schedule of training courses for staff. However, accepted that without

this, staff were unable to ensure effective care plans were written.

The provider had failed to ensure an assessment of people's needs had been completed that identified their specific requirements and preferences. This is a breach of Regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

● People were not supported by staff who had up to date training or the relevant courses to safely and effectively carry out their duties.

● The training matrix was forwarded to us following the inspection. This highlighted a number of areas of concern. For example: 11 out of 23 staff had not completed their allergy awareness course, 19 out of 23 had not completed the anaphylaxis course, 17 out of 23 staff had not completed the malnutrition in older people course with a further three having not refreshed their course since 2010, 2015 and 2018. Whilst the CQC does not detail what training providers should deliver to staff, this training formed the provider's mandatory training. Therefore, the service was non-compliant with their own policies and procedures. Only three staff had completed a course on person centred care, with a further five having completed the DoLS course in 2019. 11 out of 23 had not completed their practical moving and handling course. All identified courses were set as mandatory courses by the provider. Staff were expected to complete these as part of their induction or as required through e-learning.

● We were provided through the factual accuracy process a different training matrix from the one originally forwarded by the registered manager post inspection. This document did not provide clarity to the issues related to training. For example, the provider's mandatory training was different to the document initially forwarded in December 2019. In addition, there was confusion as to the compliance of the training. The matrix covered a one-week period of training compliance in December only. The confusion between the training record and evidence of compliance does not assure us the provider has accurate and contemporaneous training records that are reflective of staff knowledge, training and expertise."

Staff were not provided with the knowledge, training and experience to provide effective care to people. This is a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager had developed a supervision matrix. All staff were supervised bi-monthly. Appraisals had been arranged for all staff in the months of December 2019 and January 2020.

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

● At our last inspection we raised concerns related to the service's suitability to support people living with dementia. Whilst the service is not marketed as supporting people living with dementia, at the time of this inspection nine people had received a formal diagnosis, with a further nine showing signs of early onset dementia. Therefore 18 of the 25 people supported by Bracknell Care Home, showed signs of living with dementia.

● Following our inspection of December 2018, the provider assured us that all necessary changes to the building would be made to ensure people living with dementia were appropriately supported. A dementia assessment was completed by the provider in March 2019. However, the registered manager was only provided a copy of the report following our intervention in November 2019.

●The report indicated the service was not conducive to support people living with dementia. The provider had failed to forward the report to the registered manager for seven months. They had further failed to support the registered manager to commence adaptations that would support people to live safely and effectively in their environment. For example, signage indicating where specific rooms were, such as toilets,

bathrooms, lounge, kitchen were missing. There were no memory boards to assist people to their own bedrooms. Toilet seats were not colour coded to ensure people were able to retain their independence and dignity when using the toilet. Flooring, lighting, colour schemes in communal areas were not assessed or adapted to support people. This had a direct impact on the quality of life of the people using the service. The service was not making the necessary changes to accommodate the majority of people's changing needs, leading to people experiencing further confusion and increased anxiety. Guidance is available to providers to identify and illustrate simple changes that can be made to the environment that accommodates peoples changing health needs associated with dementia. The provider had failed to consider this for the people they were supporting.

● We also found that bathrooms were not adapted to meet people's needs. At the last inspection of December 2018, we noted that the only bathroom to contain a bath tub was not used. This was as a result of the location of the bath tub leaving insufficient room for a hoist and wheelchair to be used safely and effectively when supporting with personal care. Most of the people in the service require equipment to safely mobilise. We were advised by email following the December 2018 inspection that amendments would be made to the bathroom.

● At this inspection we found that no changes had been made. People were still unable to take a bath. The bathroom remained unused. Whilst there were two further communal wet rooms, people we spoke with stated, "I would prefer a bath," and "I've always liked a soak in the bathtub".

The provider had failed to ensure the premises and equipment was suitable for purpose and appropriately located. This is a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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). 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. We found that applications had been submitted as required by the service to the local authority.

● All staff were to complete training in the MCA in accordance with the provider's mandatory training. This course is to be refreshed annually so to ensure staff retain an understanding of how to ensure people are enabled to make choice.

● We found that five staff had yet to complete their MCA training, with an additional staff member needing to refresh their knowledge. When we spoke with staff they were unable to clearly explain the principles of the MCA in their practice. We did however observe one example where consent was sought and explanations were provided. The staff member was proactive in supporting the person.

● Care plans indicated that staff understanding was limited specifically when it came to MCA. For example, one person who had been assessed as having full capacity, was presented as unable to make complex decisions, "due to inability to verbally communicate properly following the stroke." This suggests that staff were unable to differentiate between ability to process information and consent, with how to verbalise or

communicate the consent. This meant that a person was being restricted the ability to make decisions for themselves.

● We spoke with the registered manager regarding this, seeking clarity on whether methods had been sought on how staff were to determine consent. The registered manager was unable to advise how consent was sought, although did reinforce consent should always be sought prior to help. Neither the care plan nor staff were able to provide feedback or evidence how consent was sought. For example, one person was being deprived of their ability to make choice. Although their care plan had been reviewed monthly since being authored in May 2019, this had not been identified.

● The service was unable to evidence where lasting power of attorneys were held by relatives or deputies for people's health and welfare. The registered manager was aware of a system that enabled this evidence to be gathered, however had yet to correlate the information. This meant the service could not assure us that authorised people were making decisions on behalf of people.

● Where people did have capacity, they were not provided with the keypad entry and exit code, to enable them to leave the premises at their discretion. This meant that people inadvertently had their liberty restricted. The provider confirmed following the inspection, that people are enabled to access the community or outside areas. Staff will unlock doors upon people's request.

The service was unable to evidence that consent was sought from the relevant person, and that staff had a comprehensive understanding of the principles underpinning the MCA. This is a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● The service worked well with health care professionals ensuring people received timely care and support with any medical needs.

A visiting health care professional commented, "The service is very good at communicating any changes in people's health." This was reiterated by the local authority who advised that the service had developed good working partnerships with other agencies to support people.

● The service had worked closely with the GP practice to develop a weekly GP round. This enabled the staff to raise any concerns related to people and for people to independently seek medical support when needed.

● We did note that records required further clarity on feedback received from health professionals to ensure information was appropriately passed onto staff, and that care was in line with people's changing needs.

● People were well hydrated. Drinks were offered throughout the day, in addition to jugs of juices left in people's rooms. We did note that concerns had been raised that these were not always in reach of people, however during the inspection, we found that all drinks were positioned within reach.

● People were offered two different cooked meals during lunch service. If a person chose not to eat what was available on the menu, alternate foods were offered. However, we did note that meals were not catering to people's specific preferences and choice. Where a person enjoyed spicy food this was not made available to them. We were told that takeaways were available if a person did not wish to eat what was on the menu.

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

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

- The service did not ensure people's diversity was explored or support was given to enable people to live their lives how they wanted.
- We found that care plans were not completed in line with how to support people's religious needs. Staff did not have the knowledge of varying religious practices, to accurately support people. For example, for one person, two faiths had been mixed up, specifically in relation to what meats could be eaten. This meant the person's religious needs were not being met appropriately by the service. Although the care plan had been reviewed on several occasions this error had not been identified.
- The person was not offered the opportunity nor was evidence available to illustrate staff had explored whether the person wished to practice their faith in the service. Whilst for this person it was noted what foods (albeit incorrectly), they could not eat, nothing was done to seek how to support their faith.
- Similarly, for another person who was known to be of a certain religious faith and denomination, their care documentation did not record how they wished to be supported during certain festivities. We spoke with the registered manager regarding this, who acknowledged the care plans required more information.
- The service supported people of many different cultural and ethnic backgrounds. However, we found that the service had not explored how to support and ensure people were able to celebrate their individuality. Information pertaining to food types, cultural practice, religious beliefs and practices, as well as people's sexuality and how to support this, was missing in care files. Where people were not native speakers of English, the service had not explored how to communicate with them in their language of choice.
- 17 out of 23 staff had completed training in diversity and equality, however had failed to recognise that people's diversity was not being explored.
- The registered persons had not ensured that the staff had the necessary training, skills or experience to ensure people were treated with dignity and respect.

This is a breach of Regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to meet people's individual preferences when supporting them.

Respecting and promoting people's privacy, dignity and independence

- We found that staff practice did not always ensure people's dignity was preserved. For example, people were left requesting to use the toilet for long periods of time.
- We observed several moving and handling practices and only found on one occasion that a member of

staff preserved the person's dignity through use of a blanket. No one was spoken with during the movement, to offer support and reassurance.

● The service currently only had two communal wet rooms that were operational. However, it was noted that neither had shower curtains in place. This meant that where people were able to wash themselves independently but required staff presence in case of risk of falls, neither their privacy nor dignity could be maintained. We spoke with the registered manager regarding this, who in turn liaised with senior management. We were assured that the shower curtains would be ordered and installed immediately following the inspection.

Where people were able to mobilise, but were at risk of falls, measures were not employed to promote independence. We found that staff restricted freedom of movement by enclosing the person in a space, or over supported them, therefore reducing their ability to retain their independence.

We found the provider had not ensured that staff had the training, knowledge or expertise to understand how to maintain people's dignity and independence in accordance with their needs.

This is a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staff did not ensure people's care and support maintained their dignity and promoted independence.

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

● The registered manager was working towards involving people and their relatives, where applicable in making decisions about their care and the home. The registered manager acknowledged that current care plans did not evidence that people had been involved in how their care was delivered.

● Meetings had commenced for residents and relatives that aimed to enable them to be involved in the service and its operations. Discussions included future activities, décor of communal areas and meals.

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.

At the last inspection the registered provider had failed to ensure that people's care and treatment plans reflected their individual needs and preferences. Care records did not contain sufficient information on how staff should support each person, in a way that reflected their individual preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that no improvements had been made in this area, therefore the provider remained in breach of Regulation 9.

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

- People's care was not personalised. Care plans did not identify how people had chosen to be supported nor illustrated any control over their needs or preferences. For example, we noted that language used within the care plans referred to people as "fussy" or "unable to communicate" when this was an inaccurate reflection. The person's preferences of food were "spicy", and for another, the preferred language of communication had not been explored.
- We found that care plans failed to provide sufficient information on how support was to be delivered. For one person we noted an instruction to staff "change pad frequently." However, "frequently" was not defined. We checked this person's records and found that on one day, according to their records, they had not been changed for over nine hours. They had further not been visually checked during this period of time, according to the hourly check record. This was a pattern that was picked up over two weeks of records checked. The person's incontinence pad was changed irregularly, with observations being completed ad hoc.
- Relatives we spoke with told us that they did not recall being liaised with in relation to sharing information to help the service formulate care plans.
- Two people we spoke with, both of whom had capacity, told us that staff had not spoken with them or sought their input in relation to how they wished to be supported. Whilst they did not feel concerned about this, they did state that they didn't truly have "control over" their care.
- We found that the service did not meet people's equality and diversity needs. People's religion was not observed, and opportunities to practice faith or culture specific measures were not employed.

This was a continued breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The care and treatment of people was not always appropriate, did not always meet their needs. Care plans did not evidence that people were being involved to the maximum extent possible or that their preferences were always being taken into account.

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.

● The service had not taken steps to comply with the AIS. Care plans did not evidence how the AIS had been applied through identifying, recording and highlighting people's individual information and communication needs in their care plans. People were not supported to communicate in a way that was effective and responsive to their needs. This led to people not being supported effectively.

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
● Whilst the service had employed activities co-ordinators and volunteers to support with activities, it was found that these were not focused on people's individual needs and interests and failed to reduce isolation.
● On day one of the inspection it was noted that although people were present during the morning session of the activity; seated in the chairs in the lounge. They were not encouraged or included in the activity. The co-ordinator focused on one person and chose to complete the activity with them. The volunteer was completing an activity independently (artwork), which was later shown to people as they sat around the room. Sporadic conversations were had with people, which did not engage people in a meaningful way. Several people slept in chairs for several hours.
● Both the TV and radio were played simultaneously on both days of the inspection, which could cause potential disorientation for a person who was living with dementia. This was not identified by staff. We intervened on day two, asking people which they would prefer on.
● The activities timetable offered to people was inaccurate, and documented activities that were not scheduled for the day. This meant that people were unclear what activities they were to be involved in should they wish.
● We observed people on both days of the inspection in their rooms, left for long periods of time without any meaningful or purposeful engagement. One person said, "I only ever see them [staff] when they are coming to support me… I am alone, I don't mind, I'd rather not engage in the activities they do, some are so childish."
● We found on day two of the inspection, a children's channel had been put on for people to watch. This was not recognised as being age inappropriate. One person commented, "They always do this. I'm not a child!"
● The service had failed to consider and establish people's likes and dislikes. Accurate social histories had not been completed, that provided insight into people's preferred activities. This meant that the activities co-ordinator did not have any information to base group or individual activities on. People who were unable to or chose not to engage were more often than not left isolated. One member of staff was noted as trying to engage people using cultural music and activities, however this staff member worked independently and in isolation to the majority of staff in the service.

This was a continued breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person was not enabling and supporting people to understand the care or treatment choices available to them.

Improving care quality in response to complaints or concerns
● People at the service knew how to complain and advised they would raise issues with the management where and when required. Relatives reported that the registered manager was responsive to complaints and

attempted to resolve concerns as soon as possible.
We found that the service maintained detailed records of investigations that were completed following a complaint with a record of the outcome.
The registered manager ensured complaints were resolved within the provider's allocated timeframe and liaised with the complainant to ensure they were happy with the outcome.

End of life care and support

- The service had developed an end of life care plan, that was written with people and their relatives, where appropriate. This contained information pertinent to whether the person wished to be resuscitated, any specific funeral arrangements and next of kin to call as the person approached end of life.
- We read compliments from families that appreciated the support that was offered to them at the time of their loved one's passing. The compliments focused on how the person was looked after, and how the family were supported during this time.

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 changed to inadequate. This meant the service management and leadership was ineffective due to inconsistency. Leaders and the culture they created did not support the delivery of high-quality, person-centred care.

At the last inspection the registered provider had failed to establish effective systems to enable them to ensure compliance with their legal obligations and the regulations. The registered provider had not established an effective system to enable them to assess, monitor and improve the quality of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that the registered provider had not made the necessary improvements required, therefore they remain in breach of Regulation 17.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The service had not established a person-centred culture that promoted and empowered inclusivity enabling the achievement of good outcomes for people. At our last inspection we found that care plans were not person centred or focused on how people wished to be supported.
- Care plans were still not individual or bespoke. They failed to establish people's specific needs and determine how they wished to be supported. For example, in one care plan it was suggested that a person did not like to socialise, this was assumed by staff without exploring and considering the fact the person was unable to communicate with others and staff had not explored effective communication techniques. By failing to pick this up repeatedly in the monthly reviews the service had inadvertently reinforced isolatory behaviour which potentially impacted on the person's mental well-being.
- People were not empowered to celebrate their individual characteristics associated with faith, culture and ethnicity. For some people this meant they were disempowered to continue with very important elements of their lifestyle, due to the service's failings.
- The provider had not ensured that they developed an environment that supported people living with dementia. People were at risk of being isolated as a result of the environment. In addition, people were more likely to display challenges that were a direct result of confusion and anxiety that the environment created. By failing to act on the report commissioned independently on the environment, and following through on the action plan from the last inspection, the provider continued to provide a service to people from an unsuitable environment.
- Inadequate staff training and understanding of people's needs meant that staff were unable to effectively carry out their duties to empower and include people. A limited understanding of people's psychological, emotional and social needs meant that care staff were often task focused. One person reported, "We are

safe here… watered fed and contained."

Continuous learning and improving care

● The service did not have sufficient evidence of audits being completed that identified shortfalls and how these needed to be actioned. This meant that we were not assured that continuous learning and improvement of care would be achieved. At the last inspection we raised concerns that the provider did not have clear systems in place to monitor and audit the service. At this inspection we found the provider had failed to develop systems to support the new registered manager to effectively monitor and improve the service. This meant that people's care was not always effective or responsive to their needs. This furthermore meant that people were not being supported in a way that was personalised to them and that was safe.

● Where reviews of care plans were completed, these did not identify errors in documentation. For example, whether a person is compliant with medication. Similarly, errors or missing information pertinent to the person's individuality, for example religious faith went unnoticed, although reviews were taking place.

● Although the service completed comprehensive trigger analysis of all incidents and accidents, including near misses, appropriate action was not taken to mitigate the risk of similar occurrences. This meant the provider could not always be assured that people were safe.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● The registered manager was new in post having taken the position at the beginning of May 2019. A new senior management team had also been recruited since the last inspection. This therefore meant that they had not yet developed a comprehensive overview of the service and a thorough understanding of the shortfalls in practice.

● The registered manager was clear that they would need to implement quality assurance systems that monitored the service and ensured that regulatory requirements were met. They acknowledged that they had not yet effectively completed the necessary baseline analysis of the service, and this needed to be a priority. There was recognition that significant changes needed to be made to the service, and that significant support mechanisms and structures would need to be developed around the registered manager, to ensure changes were achieved. These were yet to be actioned.

● The senior management team assured us that the registered manager would be supported to make the necessary changes. A registered manager from a sister home would support the registered manager specifically around documentation and paperwork, with the view that the this would free the registered manager to challenge bad practice.

● The maintenance person, although had clear information on their role, and the need to complete comprehensive environmental audits, had not done so consistently over the last seven months. This meant that the service did not ensure risks were identified and mitigated environmentally.

● The registered manager advised that this would be addressed.

● Whilst the new management team assured us that they would be developing the necessary measures to assess the service, mitigate risk and comply with regulations, at the time of our inspection we were not assured that the monitoring and oversight of the services safety and quality was effective.

The registered persons failed to consistently assess, monitor and improve the quality of the service in line with their legal obligations and regulations. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 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 registered manager ensured that they fulfilled their legal duty in the event of something going wrong with a person. We saw evidence of written communication that had been sent to the person or their representative in this situation.
● Correspondence ensured transparency. The outcome of the investigation was clearly detailed with the person or their representative being given the opportunity to liaise with the registered manager about the outcome.
● Similarly, it was noted that complaints were accurately recorded and investigated within the provider's timeframe. A comprehensive response was provided to the complainant ensuring a transparent approach. Where errors could be learnt from this was acknowledged, and action was taken.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics and working in partnership with others
● We received positive feedback from visiting professionals that the service worked well in maintaining and developing partnership in healthcare working.
● We observed that the local optician had come to the service to see people and complete relevant checks, on day one of the inspection. On day two the visiting GP was completing one of the weekly rounds.
● The local authority reported that the service engaged well, seeking clarity and support where issues were noted. However, did raise concerns that when support was withdrawn the service was unable to maintain a threshold of good practice. It was unclear how the situation would improve under new management, and whether sustainability would remain a cause for concern.
● The registered manager evidenced how they had developed links with the local community to promote new activities that would be meaningful to people in 2020. This included working with local schools and colleges, as well as developing horticultural experiences for people.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered persons did not ensure sufficient number of suitably qualified, knowledgeable and competent staff were employed and deployed in order to meet the requirements of people using the service. Regulation 18(1)(2)(a)

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered persons failed to ensure care and treatment was person centred and met people's specific needs and preferences. Care plans were not written in collaboration with people therefore people were not given the autonomy and ability to make choice. Regulation 9(1)(a)(b)(c)(2)(3)(a)(b)(c)(d)

The enforcement action we took:

In light of the current situation CQC has taken the necessary steps to review the breaches identified in respect of the above regulated activities. We have also taken account of the impact of any enforcement activity would have on the Provider and the additional pressures that they are currently facing in light of the COVID-19 pandemic. At this time, we have therefore decided against undertaking enforcement activity and to instead ask the provider to focus on driving improvement.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered persons did not ensure people were treated with respect and dignity. People were not supported to maintain their privacy, autonomy, independence or have personal characteristics protected. Regulation 10(1)(2)(b)(c)

The enforcement action we took:

In light of the current situation CQC has taken the necessary steps to review the breaches identified in respect of the above regulated activities. We have also taken account of the impact of any enforcement activity would have on the Provider and the additional pressures that they are currently facing in light of the COVID-19 pandemic. At this time, we have therefore decided against undertaking enforcement activity and to instead ask the provider to focus on driving improvement..

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered persons failed to ensure care and treatment was provided with the consent of the

Treatment of disease, disorder or injury	relevant person(s). Regulation 11(1)(2)(3)(4)

The enforcement action we took:

In light of the current situation CQC has taken the necessary steps to review the breaches identified in respect of the above regulated activities. We have also taken account of the impact of any enforcement activity would have on the Provider and the additional pressures that they are currently facing in light of the COVID-19 pandemic. At this time, we have therefore decided against undertaking enforcement activity and to instead ask the provider to focus on driving improvement.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered persons did not ensure care and treatment was provided safely. Appropriate measures had not been taken to assess, manage and mitigate risk. Medicines were not properly and safely managed, presenting a risk to people. Appropriate action was not taken to manage environmental risks, when these were known by the registered persons. Regulation 12(1)(2)(a)(b)(c)(f)(g)

The enforcement action we took:

In light of the current situation CQC has taken the necessary steps to review the breaches identified in respect of the above regulated activities. We have also taken account of the impact of any enforcement activity would have on the Provider and the additional pressures that they are currently facing in light of the COVID-19 pandemic. At this time, we have therefore decided against undertaking enforcement activity and to instead ask the provider to focus on driving improvement.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The registered persons failed to ensure the premises were suitable and maintained for the purpose for which they were being used. Regulation 15(1)(c)(e)

The enforcement action we took:

In light of the current situation CQC has taken the necessary steps to review the breaches identified in respect of the above regulated activities. We have also taken account of the impact of any enforcement activity would have on the Provider and the additional pressures that they are currently facing in light of the COVID-19 pandemic. At this time, we have therefore decided against undertaking enforcement activity and to instead ask the provider to focus on driving improvement.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons failed to ensure systems

Diagnostic and screening procedures Treatment of disease, disorder or injury	and processes were established and operated effectively to ensure compliance with the regulations. The quality of the service was not assessed, monitored or where appropriate risks mitigated to ensure the health, safety and welfare of people. Regulation 17(1)(2)(a)(b)(c)(f)

The enforcement action we took:

In light of the current situation CQC has taken the necessary steps to review the breaches identified in respect of the above regulated activities. We have also taken account of the impact of any enforcement activity would have on the Provider and the additional pressures that they are currently facing in light of the COVID-19 pandemic. At this time, we have therefore decided against undertaking enforcement activity and to instead ask the provider to focus on driving improvement.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered persons did not ensure people employed for the purpose of carrying out the regulated activity were of good character, competent, skilled to perform their duties. The information specified in Schedule 3 was not adhered to. Regulation 19(1)(a)(b)(c)(2)(3)(a)

The enforcement action we took:

In light of the current situation CQC has taken the necessary steps to review the breaches identified in respect of the above regulated activities. We have also taken account of the impact of any enforcement activity would have on the Provider and the additional pressures that they are currently facing in light of the COVID-19 pandemic. At this time, we have therefore decided against undertaking enforcement activity and to instead ask the provider to focus on driving improvement.