Bridge House (Elmwood) Limited

Bridge House 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

About the service: Bridge House Care Home is a nursing and residential care home that was providing personal and nursing care to 23 older people at the time of the inspection.

People's experience of using this service:
People were not safe and did not receive support when they requested it. The call bell system had not worked for a long time so when people tried to use their buzzer staff did not respond. Risks to individuals were not assessed and appropriately managed. Medicines were not managed safely. Recruitment practices were not robust and did not ensure staff were suitable to work at Bridge House Care Home. Lessons were not learned when things went wrong.

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; the policies and systems in the service did not support this practice. Training and supervision was variable which meant staff were not equipped with the relevant knowledge and skills. People's experience of the meals varied. Everyone enjoyed breakfast and most enjoyed lunch; tea-time meals were repetitive. Staff did not understand how to meet people's specialist dietary requirements. Systems were in place to support people with their health needs. People lived in a very pleasant environment. All areas were maintained and decorated to a very high standard.

Most people felt well cared for. However, some people experienced poor care and staff did not always respect people's privacy, dignity and confidentiality. People were supported to maintain relationships with family and friends; visitors were welcomed.

People's care needs were not identified, recorded, and highlighted in support plans. Some staff did not know how to use the electronic care recording systems and information about people was recorded incorrectly. The provider had a procedure for investigating complaints but this was not always followed in practice.

The provider's quality management systems were not effective and did not identify areas where the service had to improve. The provider and registered manager did not demonstrate they understood their responsibilities and accountability. People who used the service, relatives and staff had opportunity to share their views and put forward ideas. However, these were not always acted upon.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection: This is the first inspection.

Why we inspected: This was a planned inspection based on the recommended inspection timescales.

Follow up: We referred our concerns to the local safeguarding authority and asked the provider to send us evidence of improvements and action points. They voluntarily suspended admissions to the service. This

was used when decisions were made about our regulatory response.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, it will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe, 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 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."

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our Safe findings below.

Inadequate

Is the service effective?

The service was not effective.

Details are in our Effective findings below.

Inadequate

Is the service caring?

The service was not always caring

Details are in our Caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our Responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our Well-Led findings below.

Inadequate

Bridge House 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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
On 11 March 2019, the team consisted of two inspectors, an inspection manager, a medicine's inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. On 18 March 2019, four inspectors carried out the inspection.

Service and service type:
Bridge House 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. Bridge House Care Home can accommodate up to 66 people across three separate units, each of which has adapted facilities. Only two units were operational; one unit had not opened since the care home was registered. One unit provided nursing care. Some people lived at the service on a permanent basis; others stayed for short respite periods.

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:
We reviewed information we had received about the service since it was first registered in April 2018. We asked for feedback from other agencies such as the local authority. Providers are required to send us key information about their service, what they do well, and improvements they plan to make. This is called a

Provider Information Return (PIR) and helps support our inspections. They sent us this information in December 2018.

During the inspection we spoke with 11 people using the service, six visiting relatives, 16 members of staff, the registered manager, operations manager and human resources manager. We looked around the service and observed how people were being cared for and supported during meal times.

We reviewed a range of records. These included six people's care records in detail, five people's medication records, four staff files around recruitment and five staff files around training. We also looked at training and supervision matrices, records of accidents and incidents, audits, and other records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

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

People were not safe and were at risk of avoidable harm. Regulations were not met.

Assessing risk, safety monitoring and management

- Risks to people were not appropriately assessed and managed. Staff were unaware of how to keep people safe in relation to pressure ulcers, wound management, swallowing difficulties and specialist dietary requirements. One person was given toast even though their risk assessment stated they were at risk of choking and should have a 'soft diet'. The person ate the toast unsupervised in their room.
- Some concerns were raised about moving and handling practices. A visiting relative said they had observed care workers inappropriately trying to move their relative from a wheelchair to a seat in the lounge area. They said the staff did not have the 'correct moving and handling skills' so they had spoken to the registered manager who took prompt action. A member of staff said, "We're not really told how to move residents safely."
- Accident and incidents were not properly recorded; the provider's guidance to complete accident forms was not being followed. The management team did not know how many incidents had occurred and had not been involved in assessing and managing risk.
- Some safety equipment was not effective. People could not request assistance when they needed it because the call bell system was not working properly; this was a long standing issue. The management team were reporting the issues to the equipment provider but had not introduced additional measures to keep people safe. When inspectors highlighted the failure to manage the risk 30 minutes checks were introduced.
- Health and safety records showed identified risks were not always acted upon. For example, a safety issue had been identified with three hoisting slings since January 2018 but had not been followed up. The provider took action when we brought it to their attention. The slings were checked by an external contractor and deemed to be safe to use.
- Fire safety was not robust. Staff said they had not engaged in regular fire drills and the emergency evacuation practice records did not always show who was involved. The provider took action when we brought it to their attention. They arranged for additional fire safety training.
- The lack of identifying, assessing and managing risk meant people were not safe. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Some checks had been carried out by staff and external contractors to make sure other aspects of the premises and other equipment were safe.

Using medicines safely

- Medicines were not appropriately managed in the nursing unit. This meant staff did not administer medicines safely and people did not receive their medicines as prescribed.

•□In the nursing unit staff sometimes changed how often medicines were administered without consulting other health professionals.
•□Medicine administration records were not well completed. For example, staff did not always sign to confirm medicines were administered.
•□People did not always receive the correct dose. There were times when people had not received their medicines because they were asleep and this was not followed up.
•□People did always receive medicines at specific times even though this was important to make sure the medicine was effective. Times of administration were not recorded. This meant staff did not know when medicines, which required a minimum time between doses such as paracetamol, had been given.
•□People sometimes ran out of their medicines and this was not followed up in a timely way.
•□There was insufficient guidance for staff to understand how to administer medicines in a person centred way.
•□The lack of managing medicines appropriately meant people were not safe. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•□Management of medicines on the residential unit was well organised. People received their medicines as prescribed.

Staffing and recruitment

•□Staffing arrangements were not appropriate. There were not always enough staff on duty to meet people's needs. Observations on the nursing unit showed on both days of the inspection people did not receive care in a timely way. One person became distressed on the first day and the second day of the inspection because staff did not arrive when they needed assistance. One member of staff was asked to support a person who required support but they said they were too busy.
•□Additional staff worked in the residential unit on the second day of the inspection. This did not reflect the usual staffing arrangements and therefore, could not be relied upon as usual practice.
•□One person had been receiving one to one staffing support to help keep them safe. We were told this had been suddenly stopped by the management team but no one could explain why.
•□Feedback about the staffing arrangements from people who used the service and staff was variable. Some said there were not enough staff; others said the staffing levels were appropriate. One person who used the service said, "I've been here since October 2018, things have gone downhill, always short of staff."
•□Concerns were raised about the high volume of new workers and agency workers. On the second day of the inspection an agency worker who had never worked at Bridge House Care Home had no induction and had not been shown the fire exits. One person said agency staff did not understand their needs. One member of staff said, "A couple of times a week I have to explain to new care staff what they need to do."
•□The skill mix of staff did not ensure people were safe. Some staff were unable to carry out important tasks such as, checking a pressure relieving mattress was set correctly, even though they were experienced and the tasks should have been a key part of their role. Their performance was not monitored.
•□The lack of sufficient, competent staff meant people were not safe. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•□Some observations were positive and showed staff responded promptly, at times, and in a kind and caring way to people's requests for support.

•□Appropriate checks were not carried out before staff started working at Bridge House Care Home. Applicants did not always provide a complete employment history. Information provided by applicants was not always accurate; this had not been followed up. Two references were not always obtained. The provider

carried out criminal record checks but potential risks highlighted on returned checks were not assessed before employees commenced. The human resources manager agreed to ensure any discrepancies, and employment and reference gaps were addressed. They said the recruitment process would be closely monitored in future.

•□The lack of a robust recruitment process meant people were not safe. This was a breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

•□Individual accident and incident reports were not monitored by the management team to determine if there were any lessons to be learned. This meant when things went wrong there was no evidence of learning.

•□At the end of January 2019, the provider had identified staff had been incorrectly completing accident forms so the number of falls were not captured. The operations manager told us they were still not correctly capturing the number of falls.

•□The provider did not have an overview of incidents and accidents that occurred so could not identify if there were any patterns and trends. Therefore, potential causes were not investigated.

•□The lack of learning meant people were at risk of avoidable harm. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

•□People were not fully safeguarded from abuse, neglect and discrimination because the provider did not prioritise these areas. Staff understood they had to respond to allegations of abuse although some said they had not received formal safeguarding training. The provider shared a training matrix but this did not provide details of which staff had completed the 'safeguarding adults and children' training. A figure at the top of the report indicated it was 84%. A member of the management team who was responsible for training said there was no overview of safeguarding training.

•□The provider had reported allegations of abuse to the local safeguarding authority and maintained a safeguarding tracker which showed details of the safeguarding concern and action taken.

•□CQC were not notified about abuse and allegations of abuse that occurred. This meant we were unaware of significant events and did not have relevant information about how the provider had responded.

•□People told us they felt safe. One person said, "I came in here because I didn't feel safe at home on my own. Now I feel much safer because people are around."

Preventing and controlling infection

•□Systems were in place to prevent and control infection. Bathrooms and toilets were well stocked so appropriate hand hygiene procedures could be followed.

•□Staff followed infection control procedures by wearing appropriate protective clothing and received infection control and food hygiene training.

•□The service looked clean and no odours were noted.

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.

There were widespread and significant shortfalls in people's care, support and outcomes. Some regulations were not met.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

- People were not appropriately supported to have choice and control of their lives because the key principles of the MCA were not applied.
- Mental capacity assessments were completed about consenting to living at Bridge House Care Home but these did not always accurately reflect people's experience. For example, one person's assessment stated no restrictions were in place yet they were under constant supervision because they had one to one staffing and could not leave the unit.
- Mental capacity assessments were not completed for any other decisions such as use of bed rails and medication administration.
- Best interest's decisions were not carried out and recorded. For example, it was noted three people had bed rails but there was no evidence of Best interest's decisions.
- The provider sometimes sought authorisation when people were deprived of their liberty but this was not consistent. One person was subject to one to one staffing but an application had not been submitted.
- Staff and management were unable to tell us who had an authorised DoLS and how many people were awaiting a decision from the supervisory body. One member of staff said, "There will be people who have a DoLS." However, they did not know of any. The management team agreed to make sure staff were aware of who was subject to an authorised DoLS. At the end of the first day of the inspection a DoLS tracker was shared; this provided an overview.
- The tracker showed three people had an authorised DoLS. The individual authorisation records had specific conditions, however, the management team were unaware of these and had not acted to meet them. For example, one person had a condition for a medicines review but there was no evidence this was completed.
- The tracker showed five people were awaiting a decision from the supervisory body. One application was submitted in October 2018 but there was no evidence this was followed up by the provider.
- Staff were unsure about the principles of the MCA. Some said they had not received formal training. The

provider shared a training matrix but this did not provide details of which staff had completed the 'Mental Capacity Act' training. A figure at the top of the report indicated it was 81%.
•□Failure to meet the requirements of the MCA meant people's rights were not protected. This was a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience.
•□Staff received in-house training but this did not always equip staff with the relevant skills and knowledge. Staff said they received training when they started working at Bridge House Care Home although they did not think all key areas were covered. They said sometimes leaflets were given out rather than formal training sessions.
•□Electronic training records showed staff had completed training on induction which the provider deemed mandatory. However, a high number of subjects were covered in one day. For example, one member of staff had completed 11 topics and another member of staff had completed 14.
•□The head of care who facilitated the training said they were starting to produce certificates for the training completed. Previously they had just listed staff who attended.
•□Training records and supporting certificates showed some staff had completed specialist training, for example, stoma care, syringe driver, medicine's management and catheter care. However, some certificates reviewed were not dated.
•□Staff performance was not checked to make sure they were competent. The human resources manager said they would be introducing additional measures for staff which would include demonstrating an understanding of training and observations of practice.
•□Staff received supervision from a member of the management team although the frequency of the sessions was variable.
•□The lack of support meant staff were not enabled to carry out their role competently. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet.
•□People provided a mixed response about the quality of food. Some said they enjoyed the meals whereas others said they did not. One person said, "The food is lovely, I eat everything." Another person said, "I don't like the food, it's just delivered by a van and frozen processed food." The meals were cooked off site by an external company and then heated up prior to serving.
•□Breakfast and lunch were observed; people enjoyed the food and had plenty to eat. They were offered a variety of drinks. Fresh fruit was readily available on each unit on both days of the inspection.
•□Concerns were raised that the tea time meals were repetitive and the only options were soup and sandwiches. One person said, "I've been here since October 2018 and I don't like the food. I get fed up with the repetition. I don't care for processed food. I get enough at lunch but I'm fed up with tea time food. There is not much choice. I would prefer scrambled egg or cheese on toast." A member of staff said, "A person fancied fish and chips so I paid, they wanted it so got it; the meals are not flexible."
•□Some people had specialist dietary requirements. For example, textured meals because they had swallowing difficulties. There was a lack of information about dietary needs in people's care records and staff were sometimes unsure. The management team said they would develop information which was accessible to staff, which included hostesses who were responsible for serving meals.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law.
•□People's needs were assessed before they moved into the service to make sure the service was suitable.
•□The provider used an electronic care recording system. A standard care plan and risk assessment format was used to assess and identify people's needs. However, this was not effective because some sections were incomplete and staff were not always completing records correctly. The registered manager and provider

said they would take action to address the issues with the care recording system, which included providing additional staff training.

Supporting people to live healthier lives, access healthcare services and support: Staff working with other agencies to provide consistent, effective, timely care.
•□People's care records showed they received support to make sure their health needs were met. Appointments with health professionals were recorded, such as speech and language therapists, GPs and podiatrists.
•□One person had experienced a prolonged period where they were distressed and agitated. They were trialling medicines. Staff had not contacted health care professionals to request a review even though the medicines were not having the desired outcome. Contact was made when this was raised as a concern
•□Staff provided examples of how they worked effectively with agencies and other professionals. They told us good systems were in place to make sure people's health needs were met.

Adapting service, design, decoration to meet people's needs.
•□People lived in a very pleasant environment. All areas were maintained and decorated to a very high standard.
•□There were different areas for people to use for activities such as a cinema room, gardening room and games room although access was limited.
•□Domestic kitchen facilities provided opportunities for independence to be promoted although there was no evidence these were used.
•□People could access outdoor space which included a roof garden.
•□Everyone had individual accommodation with en-suite facilities. People were encouraged to personalise their rooms.
•□Individual accommodation had shower facilities and there were two communal shower rooms. However, the service only had one bath; one person told us they did not have a bath because they had to book it the day before.
•□Each unit had a dining and living communal room. These were spacious with floor to ceiling windows, and provided people with a view of the surrounding area. People were very comfortable and faced the view. However, the sun shone through the glass which made the room temperature very warm. There were no blinds or curtains to block the sun or ensure people's privacy was maintained. The management team said they were aware this was a problem and agreed to look at how it could be addressed.
•□Some concerns were raised about heavy doors which were closed along the corridors. One person said, "They are always closed and very difficult to open." A member of staff said, "They prevent people from being able to walk freely around the unit." A member of the maintenance team said the doors were not linked to the fire system and did not have automatic closures They said it was a known problem but the doors had to remain closed due to fire regulations.

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

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations were not met.

Ensuring people are well treated and supported; equality and diversity
•□People were not always treated with compassion, dignity, privacy and respect. Some staff did not respond when people needed support. One person told us this happened a lot. One member of staff was uncaring when they were told one person wanted assistance, they said, "Oh she's always calling out, she's got Alzheimer's, I'll go when I've finished with the other one."
•□In one unit, two people were regularly awake and made noise during the night; other people were disturbed and unable to sleep. One member of staff told us people were very upset.
•□On both days of the inspection one person did not receive support from staff in a timely way which resulted in them being left in a situation which they described as "degrading" and "embarrassing".
•□People's experience was inconsistent; this often depended on the individual members of staff who supported them. For example, when serving meals some staff told people what they were eating whereas other staff just put the meal in front of the person. When assisting people to eat some staff chatted and others held very little conversation. Staff spoke frequently to some people who used the service but there was very little conversation with others.
•□The lack of care and compassion some people experienced meant they were not treated with dignity and respect. This was a breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•□Most people provided positive feedback about the staff who supported them and the care they received. One person said, "They look after me very well." Another person said, "I've been here a year and I am well cared for."
•□Some caring and kind interactions were observed on both days of the inspection. For example, staff were affectionate when one person was leaving the service after a period of respite. Staff were singing with one person and they enjoyed this. Staff provided reassurance to one person who was unable to attend an appointment.
•□People looked clean and well groomed. Those in bed looked comfortable and told us they were.
•□Care plans had sections to record people's preferences and individual requirements including protected characteristics such as religion and sexuality. However, these were not always completed.
•□Staff had completed equality and diversity which helped them understand how to promote and protect people's rights.

Supporting people to express their views and be involved in making decisions about their care
•□People had opportunities to make choices. They chose what they wanted to eat at lunchtime; staff

referred to lists when meals were served to make sure everyone received the correct meal. People decided where they wanted to spend their time; some spent time in communal areas and others spent time in their room. People chose when to get up on a morning.

• Staff provided examples of how people were given choice and encouraged to make decisions. One member of staff said, "Some people like to get up early and others get up later. Some enjoy their own company and others like socialising. We ask people and they decide."

Respecting and promoting people's privacy, dignity and independence

• People had access to some information which helped them understand what they could expect when using the service. However, some information displayed was out of date, for example, the weekly activity timetable was four weeks old, and the menu referred to meals served the previous day.

• CCTV was in corridors and communal areas; there was a lack of signage to inform people monitoring systems were in place.

• Staff discussed personal issues about people in communal areas; confidential care records and information about people was visible to others, which meant dignity and confidentiality was not respected. This was a breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Visiting family and friends were made to feel welcome. One visiting relative said, "I come every day and the staff make me feel welcome. There is no restriction on when I visit."

• Everyone had their own accommodation with en-suite facilities. Staff knocked before entering.

• Some people used the service for short respite stays. This provided people with a break and opportunity to recuperate.

Requires Improvement

Is the service responsive?

Our findings

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

People's needs were not always met. Regulations were not met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control; End of life care and support.

- People's care and support needs were not identified, recorded, and highlighted in care plans. For example, one person's care plan was not up to date. A senior care worker said a health professional recommended the person should have thickened fluids and a soft diet but the person chose not to follow this advice. The health professional guidance could not be located and there was no information about the person's dietary requirements in their care plan. Another person's medical care plan stated most of their medicines had been discontinued and they no longer had medicines for diabetes or epilepsy. The medication administration record showed the person was still prescribed these medicines.
- Some care plans had sections that were incomplete. One person had no information about their 'culture and religion', 'abilities' and 'what is important to me'.
- Some staff did not know how to use the electronic care recording system and were not recording information in the correct place. This meant staff did not have up to date information about people's needs and how care should be delivered.
- All organisations that provide adult social care are legally required to follow the Accessible Information Standard (AIS). This helps ensure people's communication support needs are met. The registered manager said they had more work to do in this area but had started looking at how they could develop menus and resident meeting minutes, and would be providing these in an easy read and pictorial format to help ensure people's communication needs were met.
- People provided varied feedback about social and leisure activities. One person said, "My main hobby is just to sit in the dining room by the big windows and watch the birds. The scenery is lovely." Another person said, "There is not much by way of activities but I like chair yoga, bingo and charades."
- Activity timetables were displayed in the service. However, these were a month out of date and did not reflect the activities that were provided.
- The registered manager said they had identified people were not receiving opportunities to engage in social activities and were in the process of recruiting two activity workers.
- The service had some excellent facilities that people could access, such as a domestic kitchen, gardening room, cinema room, games room and roof top garden. However, use of these areas was limited. Some people were observed using the cinema room although this was not a planned activity. A notice of a scheduled film was displayed but staff said this related to a film shown previously.
- The lack of assessing and planning care and support meant people's needs were not identified and met. This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People's care plans showed discussions were held about their wishes when they became ill and at the end of life.

•□On the first day of the inspection, one person died shortly after we arrived. Staff were kind and compassionate and spent time comforting the relative and dealt sensitively with the death.

Improving care quality in response to complaints or concerns

•□Concerns and complaints were recorded but there was a lack of evidence to show actions were completed. The registered manager maintained a complaint's tracker. This showed since October 2018 the service had received 17 complaints; two formal and 15 informal. Many of the complaints were listed as resolved but it was evident from the inspection findings issue were still current. For example, between January and February 2019, three complaints were raised about limited food choices; this was still an issue but the complaints were recorded as resolved.

•□Concerns around the call bell system, staffing arrangements and management of medicines had been shared with the provider by CQC before the inspection. Assurance was given that the concerns were being addressed or were inaccurate. However, the inspection findings showed the concerns were not dealt with or responded to in an objective way.

•□The lack of operating systems effectively meant improvements were not made to the quality and safety of service provision. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•□The complaints procedure was displayed near the entrance and positioned in a prominent place so visitors would see it.

•□A visiting relative told us they had reported a concern to the registered manager who had been responsive and ensured their relative was safe. This was appropriately recorded on the complaints tracker.

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

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Regulations were not met.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility; managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; continuous learning and improving care.

- The service was not well led. The registered manager and provider was out of touch with what was happening at the service. They did not demonstrate they had an understanding of their role, responsibilities and legal requirements.
- The management team did not have a clear overview of the service. For example, they did not know about the number of people that were using the service and the number of people that had an authorised DoLS. Incorrect information was shared with CQC during the inspection.
- Quality management systems were not effective. There was a lack of monitoring by the management team who were based at the service and the provider. Significant concerns were identified throughout the inspection process; these had not been highlighted through the provider's auditing and monitoring processes.
- Policies and procedures were not always followed which meant practices did not meet the standard set by the provider. For example, the fire safety policy stated staff should attend a drill every six months. The registered manager said this requirement was not met. The provider's accident reporting procedure stated all accidents must be documented on an accident record. The registered manager said accident and incident forms had not been completed.
- Systems did not drive improvement and the provider did not respond when issues were identified. Some staff did not know how to use the electronic care recording system. They were unable to locate documents and key records. A nurse told us they did not know how to locate the previous week's daily records. The management team said staff were using the care recording system inconsistently so were recording events differently which meant events such as falls, safeguarding, accidents and incidents were not being captured. The registered manager said this was identified in January 2019 and had not been rectified when the inspection was carried out in March 2019.
- The human resources manager said a new recruitment process should have been implemented in January 2019. However, recruitment that was carried out in February 2019 did not follow the new procedure.

- The registered manager said following concerns raised on the first day of the inspection, on 14 March 2019, a new accident and incident reporting system was implemented, which included completing an accident form. On 18 March 2019, the second day of the inspection, the senior worker in charge of the residential unit was not aware of the changes and did not know they should be completing accident forms.
- The lack of robust quality assurance meant people were at risk of receiving poor quality care. This was a

breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Notifications about deaths at the service had been submitted to CQC. The registered manager and provider had failed to meet their legal requirements because no other notifications had been received even though significant events had occurred. This meant CQC did not know about serious injuries, abuse and allegations of abuse, events that stop a service running smoothly and safely, and DoLS authorisations. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Registration) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others.

• People who used the service and staff had opportunities to share their views and put forward ideas although these were not always acted upon. People told us they had raised concerns about the call bell system and lack of food choice, and records we reviewed confirmed this. Both issues had not been resolved. One person said additional ham and egg fillings had been introduced in response to concerns about the repetitive tea time choices but soup and sandwiches was still the only option.
• A monthly bulletin, 'We are listening to you' was published. This showed concerns had been raised by visitors about the length of time they had to wait before the door was answered. The provider said they were linking door access devices to the telephone systems and reception staff would be moved to the front of the house. This was actioned. They also said they had improved Wi-Fi in response to people's comments.
• A resident and relative's meeting was held on 6 March 2019; the registered manager was in the process of gathering everyone's comments and said they would be developing an action plan.
• Staff told us they had opportunities to talk to the management team and put forward suggestions. A notice advertising the next team meeting was displayed. The agenda items included, 'resident feedback, positive communication/team work, training, new staff handbook, documentation, pagers and recruitment update'.
• The local authority and clinical commissioning team had been supporting the provider to help drive improvement over a number of months. During this period they received assurance that recommendations had been followed however this does not appear to be the case.