Buckland Rest Homes Limited

Greenbanks Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Greenbanks Care Home is a residential care home providing personal care and accommodation for up to 30 people. The service provides support to older people, some of whom were living with dementia. At the time of our inspection there were 22 people using the service. The home provides care for people in one building across two floors.

People's experience of using this service and what we found
At this inspection the provider had failed to address some of the breaches of regulation identified at our previous inspection in February 2023. The provider had submitted an action plan following the last inspection but had failed to make or sustain improvements in these areas. The provider had failed to meet the warning notices that had been issued.

Quality and safety monitoring systems were not robust. Governance processes and systems in place to help ensure the safe running of the service had not identified all the concerns we found. Systems to identify and mitigate risk were not effective. Medicines were not always safely managed including controlled drugs. Risks related to the premises were not always safely managed, this included risks related to fire safety.

Potential risks to people were not always safely managed. Records used to monitor and review people's care had not been fully completed and kept up to date. For example sections of care plans and other care records had not been updated to reflect changes in people's needs. Improvements were required to reduce the risk of people's experiencing social isolation through personalised activities.

Safe and effective infection control processes were not fully embedded to ensure people were protected from the risk of infection; further work was needed to ensure good infection control processes were being followed.

The provider did not ensure recruitment checks were carried out in line with the regulations.

Some areas of the environment needed updating to ensure it met the needs of people. We made a recommendation the provider review and implement dementia friendly guidance in providing an appropriate home environment to best meet people's needs.

There had been improvement with meeting the requirements of the Mental Capacity Act 2005 (MCA). We have recommended the provider review all mental capacity assessments for each person to ensure they maintain an accurate and complete record of decisions taken in relation to their care. For example, night checks and modified diets. People's consent was not always sought for having treatment in a public area.

There had been improvement in staff training and the service had been working with other health care professionals to ensure that staff were knowledgeable in conditions people were diagnosed with.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 30 March 2023) and there were breaches of regulation. The provider submitted an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

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

You can see what action we have asked the provider to take at the end of this full report.

Enforcement and Recommendations
We identified the provider failed to fully address the action we told them following our last inspection. There were continued breaches in relation to safe care and treatment, good governance, and fit and proper persons employed at this inspection. We have further identified breaches in relation to dignity and respect, and failure to notify at this inspection.

Please see the action we have told the provider to take at the end of this report.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
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**

Greenbanks 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 Health and Social Care Act 2008.

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

Inspection team
This inspection was undertaken by 2 inspectors, 1 medicines 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.

Service and service type
Greenbanks is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Greenbanks is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection

This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 3 members of staff, including the registered manager and regional manager. We spoke with 7 people using the service. We received telephone and email feedback from 5 relatives. Emails were sent to staff requesting feedback, however, no responses were received.

We reviewed sections of 5 people's care plans, 10 medicines records, daily notes and risk assessments. We reviewed policies and procedures, training records, staff recruitment files, audits, governance arrangements for the safe handling of medicines and other records in relation to the running 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.

At our last inspection we rated this key question inadequate. At this inspection the rating for this key question has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management
At our last inspection we found the provider failed to manage risks to people's health and safety, this placed people at risk of harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found improvements had not been made to effectively reduce risks and the provider remained in breach of Regulation 12.

● Following our inspection in February 2023, we raised concerns with Hampshire & Isle of Wight Fire & Rescue Service about the management of fire risks in the service. Following this, the fire service issued the provider with a schedule of fire safety improvements needed. At this inspection some action had been taken, but there were further improvements needed. This meant we could not be assured risks from fire were robustly assessed and mitigated.
● Fifteen fire doors throughout the home were not effective. This included doors not closing fully into their frames, self-closing devices not operating, missing intumescent strips, and doors stating 'Fire Door Keep Locked' being unlocked. This placed people at increased risk of harm. Due to the level of concerns around fire safety, we escalated this to Hampshire and Isle of Wight fire and rescue service, who have contacted the service.
● Risks related to the premises were not always safely managed. For example, there were no window restrictors in place for 2 windows and other window restrictors were broken. These did not ensure the safety of people living with dementia. Cupboards adjacent to bedrooms contained cleaning products that were open and accessible. When not in use the keys were hung on the outside frame of the door which was easily accessible. This meant people were at risk of harm. On day 2 of inspection a window restrictor had been fitted to 1 room however, this was ineffective as it did not lock. The registered manager stated they were waiting for a new one.
● Oil filled radiators in bedrooms and radiators throughout the building were not covered. Temperatures were recorded daily but this was not effective as we found 3 radiators that were above 43 degrees Celsius. This placed people at increased risk of burns. Further guidance was given and signposts to the Health and Safety Executive for further guidance on hot surfaces control and mitigation.
● Potential risks to people were not always safely managed. For example, a person was assessed as needing staff assistance with meals, but they were observed using their fingers to eat their dinner with steam coming off the food. When pudding was served the inspector intervened and requested the temperature the pudding was served at, this was 94 degrees Celsius. Staff were then asked to sit with this person to ensure they were not placed at further risk of burns.
● A staff meeting documented that no more than 2 senior staff go outside at the same time for smoking

breaks. We observed 4 staff going outside in the garden to have a cigarette together, during this time 7 people in the lounge were not being monitored. Two people in the lounge were at high risk of falls. Feedback from relatives included, "I often see 3 or 4 staff going out to the smoking shed together."

● Some people's nutritional plans contained inconsistent information about levels their food and fluid should be thickened to, using the recognised International Dysphagia Diet Standardisation Initiatives (IDDSI). This is important so all staff supporting people to eat, and drink would know what the level was to reduce risks of choking. For example, a person assessed as requiring a minced and moist diet was recorded on the kitchen menu as having a normal diet. Another person's care plan documented requiring thickened fluids but further down the care plan stated they had thin fluids. This placed people at increased risk of harm.

● Risks related to people's health and medical conditions were not always managed safely. For example, the guidance in a person's diabetes care plan contained conflicting information with the care plan from the district nursing team. A person living with a long-term condition did not have a relevant care plan providing guidance to staff on how the condition affected them and how to manage the condition effectively if it got worse. This increased the risk to people through their conditions not being appropriately managed.

Failure to manage risks to people's health and safety. This was a continued breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection the provider sent evidence that some radiators now have covers in place.

Using medicines safely

At our last inspection we found people's medicines were not being properly and safely managed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found improvements had not been made to manage medicines properly and safely and the provider remained in breach of Regulation 12.

● Recording for the administration and management of medicines was not always accurate or consistent. We could not be assured medicines were administered as the prescriber intended and managed safely.

● Medicines were not always administered as the prescriber intended. This included 'time sensitive' medicines. These are medicines that need to be given at a certain time to make sure they are safe or work effectively.

● Medicines including controlled drugs were not always managed according to guidance.

● Documents to help staff administer when required 'PRN' medicines were not always adequately person centred to support staff in administration. There was insufficient recording as to why the medicine had been administered or if it had been effective. This information is useful in monitoring a person and deciding if they needed reviewing by the doctor.

● Care plans and risk assessments were not always sufficiently detailed to reflect the prescribers' intentions and/or current care provision, these were not in place.

People's medicines were not being properly and safely managed. This placed people at risk of harm. This was a continued breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We requested the provider carry out a full medicines audit which they completed and provided after the inspection. This did not reflect the issues we found on this inspection.

Staffing and recruitment
At our last inspection we found the provider failed to ensure appropriate staff recruitment processes were in place. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found improvements had not been made to ensure appropriate staff recruitment processes were in place and the provider remained in breach of Regulation 19.

● Recruitment checks were not always carried out in line with the regulations. The provider's recruitment policy did not meet the requirements of Regulation 19.
● We reviewed recruitment records for new staff. One staff member did not have evidence of an enhanced Disclosure and Barring Service check in place or satisfactory evidence of their conduct in previous roles relating to health and social care, or children or vulnerable adults. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. Two staff had unexplained gaps in their employment history. This put people at risk of not being supported safely.
● People were asked if there were enough staff to get the care they needed when they wanted it. Feedback included, "No, they're a bit short staffed. There's a few more now but we've been a bit short staffed," "Oh I would think there are but you never see them altogether so it's difficult to say," and "There's always somebody about."
● The registered manager assessed people's needs using a dependency tool to determine appropriate staffing levels.

The failure to ensure appropriate staff recruitment processes were in place and carried out. This was a continued breach of Regulation 19(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following this inspection we signposted the provider to information and guidance on meeting the requirements of Regulation 19.

Preventing and controlling infection
At the last inspection the provider had failed to ensure that systems to prevent and control infection were implemented effectively. This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider remains in breach of Regulation 12.

● Following our inspection in February 2023, we raised concerns with the Hampshire and Isle of Wight Integrated Care Board. Following this, they carried out an infection control audit which covers 7 areas of infection control within the home. They issued the provider with an action plan of improvements needed. At this inspection some actions had been taken, but there were further improvements needed. This meant we could not be assured that systems to prevent and control infection were robust or effective.
● There were concerns with infection control within the home. The service was not always clean, there was visible dust on some surfaces, cobwebs at high points, florescent lighting in corridors were either missing, cracked or contained dead insects. Some areas of the home had strong odours present. Records of cleaning were incomplete and inconsistent.
● On day 1 of inspection we observed an infestation of flying ants between 2 bedrooms. We informed the

registered manager who stated they would deal with it immediately. On Day 2 of inspection they were still present. Following this inspection the registered manager confirmed the infestation of ants had been cleared.

● We observed staff going outside for regular cigarettes then re-entering the building and continuing work without washing their hands. We observed management wearing nail varnish, rings and bracelets. This did not meet current infection prevention and control guidance.

● There were risks of cross-contamination. Staff were seen using the same stand aid sling for 2 people. People should have their own slings to prevent cross contamination. A wheelchair store next to the lounge and dining room had a strong odour. Upon investigation with the registered manager there were 2 wheelchair cushions were giving off odours. This cupboard was accessed by staff to retrieve wheelchairs throughout the day, this had not been identified. These were removed immediately.

The provider had failed to ensure that systems to prevent and control infection were implemented effectively. This was a continued breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

● There was a system to monitor incidents and risk management reports. Some of the incident records were not always robustly recorded or completed. This did not ensure that analysis and lessons to be learnt about how incidents occurred were acted on due to insufficient documentation.

● There were policies and procedures in place to support staff in safeguarding people. Staff had completed safeguarding training.

● People told us they felt safe and were happy. A person said, "Yes, well, what would make me not safe. I know most people." A relative told us, "I believe my [relative] has always felt safe, well cared for and happy."

Visiting in care homes

● Visiting arrangements at the home were in line with current guidance.

● Feedback from people included, "This week I've had a lot of visitors." One relative told us "I have always been able to visit [relative] and have been able to take them out."

● During our inspection we saw visitors arriving and visiting their relatives in the home.

Requires Improvement

Is the service effective?

Our findings

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

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

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 MCA 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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

At our last inspection the provider had failed to obtain consent from the relevant person for care or treatment decisions. This was a breach of Regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- People's consent was not always sought for having treatment in a public area. For example, we observed people having treatments such as wound dressings and blood monitoring being carried out in the lounge with people present. No privacy screens were used and the opportunity to be taken to a private room was not offered.
- There had been improvement with meeting the requirements of the Mental Capacity Act 2005 (MCA). Improvements were still required to ensure all specific decisions needing to be made for people who lack capacity to consent have a mental capacity assessment completed. Decisions made in people's best interests still needed to be assessed and documented. For example, in relation to night checks and modified diets.

We recommend the provider review all mental capacity assessments for each person. This is to ensure they

maintain an accurate and complete record of the care and treatment provided to people, and of decisions taken for their care.

Staff support: induction, training, skills and experience
At our last inspection the provider had failed to ensure staff had received appropriate training. This was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 18.

● The provider had been working with outside professionals to make improvements to staff training. This was evident as staff had received training in areas relevant to their job role. We could not be assured that all staff administering medicines were up to date in medicines administration training or competency assessment. The provider failed to send competency assessments for moving and handling, and infection control.
● Staff received an induction before working at the home, and staff were receiving supervisions in line with the provider's policy.
● People and relatives felt staff were well trained and knowledgeable. One person told us, ''Oh I think so because they're always sort of meeting and discussing things. I'm sure they're well trained.'' A relative said, ''They do seem to quite often be holding some training or refresher training.''
● We observed a person living with dementia respond positively to a member of staff and the approach they used.

Supporting people to eat and drink enough to maintain a balanced diet
● Information about people's specific dietary needs was not consistently recorded within their care plans and their modified diet levels were not always correctly reflected on the kitchen record. We have commented on this further in the safe section of this report.
● People were supported to eat and drink enough to maintain a balanced diet. The home had a 4-week menu which the registered manager told us was devised with input from people.
● During our inspection the kitchen was having an area of floor replaced. The cooker had been moved into the middle of the kitchen to allow works to be completed, meals were still being prepared and cooked in the kitchen. There was no evidence of screening to protect the food area from dust and debris during this process which had commenced 6 days prior to inspection.
● There was mixed feedback about the meals provided, comments from people included, "Oh very, very nice. You generally have two main meals to choose from and a pudding," "Normally it's good but they've had a bit of trouble recently because the kitchen's being re done or something," "Quite reasonable, I don't know really about choice, I take what comes," and "It seems very disorganised around meal times and sometimes there is not enough or enough variety."
● We observed mixed interactions between staff and people. Some staff did not interact with people during the dining experience even when they required support. We also saw another staff member interacting positively with people.

Assessing people's needs and choices, delivering care in line with standards, guidance and the law
● The provider completed assessments prior to people moving into the home. A person living with a long-term condition indicated on the pre-admission assessment did not have a specific care plan in place. This would provide guidance to staff on how the condition affected them and how to manage the condition effectively if it got worse.
● The provider utilised a range of nationally recognised tools to ensure people's needs were assessed. For

example, the use of the Malnutrition Universal Screening Tool (MUST) to monitor people's risk of malnutrition. There was evidence of people being weighed regularly.

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

- The bathrooms on the ground floor could accommodate people who required support with moving and transferring to the bath. There was a bathroom/wet room on the first floor that would be difficult for people to use independently as there were 2 wooden chairs, a commode frame, a Zimmer frame, and a mobile hoist stored in there.
- Aspects of the home's décor were not dementia friendly in line with best practice guidance. Several bedroom doors had no personalisation to help orientate people who had dementia.
- People's bedrooms were furnished and adapted to meet their individual needs and preferences. Pictures and soft furnishings evidenced people, or their relatives were involved in adapting their rooms.
- There was enough space for people and the building was accessible for people with different mobility needs. Floors could be accessed by a lift and stairwells.

We recommend the provider review and implement dementia friendly guidance in providing an appropriate home environment to best meet people's needs.

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

- There was evidence of working with other agencies such as district nurses, GP's and the local authority.
- People had access to regular healthcare services such as GPs, opticians, and chiropodists, and were supported to attend regular appointments in relation to their health conditions. People confirmed this and comments included, "Opticians and dentists, I do that myself, my family member takes me." and "I've been to the dentist."
- A relative told us, "They have a visiting podiatrist who attends [relative], visiting optician and dentist and also a hairdresser."

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

Respecting and promoting people's privacy, dignity and independence

- People's privacy and dignity was not always respected. For example, a person was being assisted to eat by a member of staff standing over them for 5 minutes, rather than promoting their dignity and sitting with them. There was no dialogue from the staff member to the person about the food, or if the person was ready and if they actually wanted it.
- Staff had received training in privacy and dignity. We observed this was not always maintained in practice. A staff member bringing in a person into the dining room, in a wheelchair, asked other staff, "Where do you want to sit her." completely ignoring the person and not using their name. This was done without asking the person their preference.
- Feedback from a person included "[Staff] come in when I'm sitting on the loo, they don't knock on the door. You get used to showing yourself without any clothes on."
- One person was stood at the food hatch where the chef was. The chef gave them a banana and some grapes, with both being held in their hand. A staff member said to the chef, "Has she just taken that out of her mouth." speaking over the top of the person's head without any acknowledgment to them. This was not respectful and demonstrated people were not always treated with dignity by staff.

The failure to ensure people's privacy and treat them with dignity and respect was a breach of Regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to express their views and be involved in making decisions about their care; Ensuring people are well treated and supported; respecting equality and diversity

- Care plans evidenced people and families had been part of their initial assessments. However, there was no evidence people and relatives had been involved with changes and updates to their care plans.
- Feedback from people and relatives confirmed they were not involved with care planning reviews.
- Relatives we spoke to were generally positive about staff. One told us, "Staff treat [relative] very well," others said, "Yes they are wonderfully kind and caring" and "The whole team are kind and caring and make time for each resident."
- People told us staff treated them kindly. A person said, "Amazingly, I'm so spoilt. They're all lovely to me, we haven't got one nasty person here."
- People were able to spend time with their friends and relatives in their own bedroom as well as communal areas.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People were not always supported to follow or engage in meaningful activities, especially people who spent time in bed as there appeared to be limited interaction. There were limited opportunities for reminiscing, occupation, or activities to support people in feeling valued.
- From our observations, care staff were very task focused. This led to varying experiences depending on the person's abilities to be able to engage in communal activities and those who may not get the option due to their health conditions.
- Feedback from people regarding activities was mixed. Comments included, "No, not supported, I used to go out in the garden." and "Oh yes, there's painting, there's drawing, there's cooking." Relatives' feedback included, "[Relative] needs support to go into the garden but this doesn't happen," "[Relative] likes to chat and would love 1-1 time to do this." and "I've seen [relative] involved with a seated Pilates morning, they also play Bingo."
- The home displays an activities planner in people's bedrooms to keep people updated with the current week's activities.

We recommend the provider review and implement a better system to monitor and ensure that people living with dementia or who have limiting health conditions receive personalised activities.

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

- People had care plans and records in place which were used to monitor and review people's care. Some were detailed and person centred, there were some that were not in place when they should be, and some that were inconsistent or out of date. Sections of care plans and other care records had not been updated to reflect changes in people's needs.
- Care plans did not always have adequate information for staff to provide consistent, person-centred care. One person's care summary briefly describes agitation and challenging behaviour. The care plan did not include positive behaviour strategies, triggers and diversion techniques. This meant that staff members may not have had the appropriate knowledge required to respond to the person's needs.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in

relation to communication.

● People's care plans included their communication needs and described how these should be met. Some people's care plans described how people communicated and if they needed any aids to support them.

Improving care quality in response to complaints or concerns
● The provider had a complaints policy and process in place which was available to people, relatives, and visitors.
● People and their relatives told us they knew how to make a complaint. They said they would speak to the registered manager. For example, one person said, " If I ever want to complain, I go to [registered manager]. I've never made one. If I'd got something concrete, I'd be happy to complain."

End of life care and support
● People's wishes and care for the end of their lives had been considered.
● People's cultural needs were referenced in their end-of-life care plans.
● People's friends and relatives had been consulted about the end of life needs of the person.
● Staff had received end of life care training.

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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
At our last inspection we found the provider's systems to assess, monitor and improve the service were not sufficiently robust. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found improvements had not been made and the provider remained in breach of Regulation 17.

● At this inspection there were repeat breaches of regulations relating to safe care and treatment, good governance, and fit and proper persons employed. We identified new breaches in relation to dignity and respect, and failure to notify.
● The provider's governance system was ineffective in identifying where fundamental standards were not being met or driving improvements where required. They were not robust and did not provide an effective system to systematically identify the continued significant concerns identified on inspection.
● We could not be assured all staff administering medicines were up to date in medicines administration training or their competency assessed in the administration of medicines.
● The service had processes in place for the ordering and disposal of medicines. These were not effective. Medicines audits were completed by the provider. The audits did not always identify actions to be taken to make the required improvements regarding the issues we found during the inspection.
● Records for people using the service were in place. Some were inconsistent, and some were incomplete in sections. Care plan audits did not always pick up on the information that was lacking such as choking risk assessments and the inconsistencies with people's modified diets. People's consent was not always sought for having treatment in a public area.
● The provider had failed to maintain an accurate, complete and contemporaneous record in respect of each service user. This included records of the care and treatment provided to people, and of decisions taken in relation to their care. The provider had failed to fully assess, monitor and mitigate the risks relating to the health, safety and welfare of people and others at risk as described in other sections of this report.
● The provider had not displayed the rating from our last inspection in the entrance of the home in line with regulatory requirements. We discussed this with the registered manager on the first day of the inspection and this was addressed

Systems to assess, monitor and improve the service were not sufficiently robust. This was a continued

breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The registered manager did not fully understand their legal responsibilities. Statutory notifications were not always sent to CQC when required. We noted not all incidents including pressure wounds had been reported by the provider to the local authority safeguarding team or CQC when appropriate.
● Statutory notifications are important because they inform us about notifiable events and help us to monitor the services we regulate.

Failure to notify is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Following our inspection, the registered manager submitted the required notifications, and assured us they will notify us correctly moving forward.

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 understood the duty of candour requirement and the need to be open and honest in the event of certain notifiable events when something goes wrong.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● People did not always receive dignified, person-centred care and improvements were needed to develop the culture at the service.
● People told us the home was managed well. Feedback included, "It's not too badly managed but they're having difficulties getting people to come and work I think." and "I think it's excellent but to be honest, I have nothing to compare it to."
● Feedback from relatives regarding if they felt the home was well managed was mixed. Comments included, "From what I see I would say it is managed well." and "Not very responsive to emails, the registered manager says the right things but it never happens or changes may happen but usually only last a few weeks."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Staff quality surveys indicated mixed feelings around some issues such as being listened to, lack of appreciation, more support from the senior management and respect. The provider was unable to evidence the outcomes and actions taken from these quality surveys.
● There were no records of meetings with people or relatives to gain their views about the home. Feedback from people and relatives confirmed this. The registered manager told us that a residents and relatives meeting was booked for June 2023.
● Staff updated with important information and changes through regular team meetings and daily briefings.

Continuous learning and improving care; Working in partnership with others
● The provider could not demonstrate continuous learning and improvement. Some of the breaches in regulation which were identified at the last inspection in February 2023 remained in breach. Some new breaches in regulation were identified on this inspection.
● Since our last inspection the home has been closely working with other partnerships such as the local authority quality and safeguarding team and the integrated care board to make to required improvements. Some improvements have been made but there are still areas where the service needs to develop more

robust systems to identify and improve the safety and standard of care people receive.

- Records confirmed a range of healthcare professionals had been involved with people's care.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Failure to notify is a breach of Regulation 18 Care Quality Commission (Registration) Regulations 2009.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The failure to ensure people's privacy and treat them with dignity and respect was a breach of Regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that systems to prevent and control infection were implemented effectively. Failure to manage risks to people's health and safety. People's medicines were not being properly and safely managed. This placed people at risk of harm. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

	Systems to assess, monitor and improve the service were not sufficiently robust. This was a continued breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
Regulated activity	**Regulation**
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The failure to ensure appropriate staff recruitment processes were in place and carried out. This was a continued breach of Regulation 19(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.