Ruddington Homes Limited

Balmore Country House

Inspection report

245-7 Loughborough Road
Ruddington
Nottingham
Nottinghamshire
NG11 6NY

Tel: 01159213006
Website: www.my-care.co.uk

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

Summary of findings

Overall summary

About the service
Balmore Country House is a residential home providing personal and nursing care to up to 76 people. The service provides support to older people, some of whom may be living with dementia. At the time of our inspection there were 44 people using the service.

People's experience of using this service and what we found
People's medicines were not managed safely. There were concerns about the way medicines were stored, used, and disposed of. This placed people at significant risk of harm. Areas of the home were not clean. This placed people at risk of the spread of infection. Some parts of the premises were not safe, equipment was left in people's bedrooms and not stored safely. This placed people at risk of harm.

There were sufficient staff in place; however, we had concerns about some of the staff and their approach and attitude to providing safe and compassionate care for people.

The home was not well managed. The provider had not ensured the registered manager had sufficient support to carry out their role effectively. Staff performance was inconsistent and poorly monitored. Some staff carried out their roles well, others, did not. This has impacted people's health and safety. Quality assurance processes were ineffective. They had not highlighted most of the significant concerns we have identified during this inspection. This has placed people at risk of harm.

Staff had received the training the provider had deemed required for them to carry out their role effectively. However, staff performance was not appropriately monitored. Some poor staff actions have placed people at risk of harm. The premises was not always monitored for risk that could impact people's safety. People did not always receive care and support in accordance with their assessed needs.

Some people felt lonely with limited interactions with staff and other people. We found people's dignity was not always respected. Staff did not respond quickly enough to people who required their support to lead a dignified life. At times inspectors had to step in to reassure people and to seek the help they needed. Independence was not always encouraged and at times we witnessed staff actively discouraging a person's attempts at independence.

Staff were not always responsive to people's needs. Staff did not always call people by their preferred name. At times when we raised concerns with some staff they were reluctant to accept our findings.

We did observe some positive interactions between staff and people. Some staff were kind and caring with their approach and people liked this. Accidents and incidents were investigated and reported appropriately.

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

supported this practice.

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 good (published 23 April 2020).

Why we inspected
The inspection was prompted in part due to concerns received about the provider's management of incidents that affected the safety of people living at the home. A decision was made for us to inspect and examine those risks.

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

Although we found no evidence during this inspection that people were at risk of harm from this concern, we did find significant failings in other key areas of care and governance.

The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

We have found evidence that the provider needs to make improvements.

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

Enforcement and Recommendations
We have identified breaches in relation to governance, medicines, premises and equipment and the provision of dignified care 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 request an action plan from 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 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not 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.

Balmore Country House

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 carried out by 3 inspectors.

Service and service type
Balmore Country House 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. Balmore Country House is a care home with 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.

Inspection activity started on 8 November 2023 and ended on 16 November 2023. We visited the location's service on 8 and 9 November 2023.

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 and professionals 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

We also contacted Healthwatch who are an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We used all this information to plan our inspection.

During the inspection
We spoke with 6 people who used the service, and 4 relatives to ask them about their experience of the care provided. We spoke with care staff, senior care staff, clinical lead, an agency nurse, domestic staff, chef, assistant manager, registered manager and operations manager. We spoke briefly with the nominated individual. They are responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included all or parts of 11 people's care records, medication administration records and the daily notes recorded by care staff. We looked at 3 staff files in relation to recruitment and staff supervision and a variety of records relating to the management of the service, including policies and procedures and training records.

We asked the registered manager to provide us with a variety of policies and procedures and additional information after the inspection. All information was sent within the required timeframe.

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 good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

● People were not protected from the risks associated with medicines. Medicines were not managed safely.

● Medicines were not stored safely. Thickener was found in unlocked drawers in 2 people's bedrooms with their dispensing labels removed. Thickener for 2 people was also found in the office located next to the main lounge. One of those people had sadly passed away prior to the inspection but their thickener was still in use. None of those thickeners had opening dates and were stored in an unmonitored environment. Failure to ensure the safe storage of prescribed thickeners meant it was not clear if the thickener would be safe to consume. This placed people at risk of harm.

● A relative raised a concern with us about the use of thickener for their family member. They said, 'My family member needs thickeners in all liquids and on occasions drinks have been brought in with none in, we have had to remind staff to do it.' We asked a staff member about the storage and use of thickeners. The staff member told us one tub of thickener was kept on the medicines trolley to be used for different people "just in case anyone needed it." The use of thickener for multiple people increases the risk of cross contamination to those service users. This placed people at risk of harm.

● We found further concerns with the storage of medicines. We found multiple prescribed medicines for numerous people in a box on the floor of a storage cupboard. Some medicines boxes were open, and some were sealed. The door to the storage cupboard was locked; however, the code for the door was written above the keypad entry system. This box included medicines that could cause people harm such as behaviour altering medicines such as Lorazepam.

●Staff were not aware the medicines were in this room. The room was easily accessible and not temperature controlled. Failure to ensure the safe and secure storage of medicines placed people at risk of not receiving their prescribed medicines and of ingestion of medicines not meant for them.

●Controlled drugs were not disposed of safely or in line with best practice guidance. A large, controlled drug destruction kit was found in an unlocked cupboard within the medicines room. The kit contained at least 33 small white tablets which could be easily picked out of the controlled drug destruction kit. Failure to ensure controlled drugs are rendered irretrievable if refused, increases the risk of redivision of controlled drugs which placed people and the wider community at risk of harm.

●We found other significant concerns with the management of people's medicines which we have discussed with the provider so they could take immediate action to ensure the risks to people were reduced.

The provider's failure to ensure the safe management of people's medicines placed people at increased risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● People were at risk because there was poor prevention and control of infection and a poorly maintained environment in places.
● Some areas of the home were in a state of disrepair meaning it could not be cleaned effectively. Skirting boards, doors and walls were found to be chipped in many areas of the home. We observed the carpet in a person's bedroom to be stained with brown marks. Clinical waste was found to be taken out of bins and left on the floor of bathrooms which people were accessing. Dust and dirt was found in bathrooms and sinks. This placed people at increased risk from the spread of infection.
● A person's bedroom was observed to have been cleaned by a staff member. However, following the cleaning of the bedroom, brown stains remained on the wall. We also found this person's bed linen to be marked with brown stains and dried blood after the room had been cleaned. Failure to ensure effective housekeeping and maintenance was completed placed people at risk of infection.
● People were at risk of cross contamination as we found personal hygiene products in the wrong people's bathrooms. We found skin cream in one person's bathroom which belonged to another person. Failure to ensure people only used their own personal hygiene products increased the risk of cross contamination of infections. This placed people at risk of harm.
● Pressure relieving equipment was found to be dirty. We found 2 pressure relieving cushions which had embedded dirt present These were heavily stained with urine and were malodourous. This was immediately reported to a staff member who advised they would dispose of both cushions. The following day we noted one of the dirty pressure cushion's we observed was found in the upstairs bathroom next to the bath. Failure to ensure pressure reliving equipment was cleaned effectively or disposed of if no longer fit for purpose, placed people at risk of harm from the spread of infection.
● Some moving and handling equipment was found to be dirty. We observed a person being transported in 2 different wheelchairs on each day of the inspection; both of which were dirty. We observed a further wheelchair in a different person's bedroom to be very dirty with brown stains on the seat. Failure to ensure moving and handling equipment was cleaned placed people at risk of harm from the spread of infection.

The provider's failure to ensure the safe infection control practices placed people at increased risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
● The provider's approach to assessing and managing environmental and equipment-related risks was inconsistent.
● A small toilet was not locked. This room was small and if a person accessed this room and fell it would be difficult for staff to support the person to get out safely. The registered manager told us this was a staff toilet that was not for use for people living at the home and should have been locked. Staff had failed to do so, placing people at increased risk of harm.
●A shower room had unsafe flooring which posed a risk of falls to people. The water temperature in this room far exceeded the maximum safe temperature. The emergency call bell was also out of reach. Again, the registered manager advised us this room should have been locked but was not. This placed people at risk of harm.
●A small kitchenette off the main lounge had a large radiator and exposed pipes and they were hot to touch and uncovered. These would cause a risk of burning should a person touch or fall against these pipes.
● Fire extinguishers had been removed from a wall the but the hooks they were hanging on were still on the walls and would be dangerous if people tripped into them. We were told the removed fire extinguishers had been removed on the advice of Fire Service; however, they were propped up outside the sluice door rather than being put away safely. If these fell on a person they could cause a risk of harm.

The provider's failure to ensure safe premises and equipment placed people at increased risk of harm. This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Three of the 4 relatives we spoke with told us they felt their family members were safe at the home.
● Care records overall were well completed. We did note some discrepancies with post-fall management and monitoring which we discussed with the registered manager. They advised they would ensure all documentation was appropriately completed to reflect the actual post-fall care being provided.

Staffing and recruitment
● Poor and/or ineffective staff performance was not always recognised or properly responded to, and people were at risk of harm as a result.
● Staff did not always carry out their duties safely and effectively which directly contributed to the concerns identified during this inspection and recorded in this report. As a result, people have been placed at increased risk of harm.
● The provider's dependency assessment showed there were enough staff to provide people with care in accordance with their assessed needs. However, following the risks to people's health and safety identified during this inspection we do have concerns as to the effectiveness of the staff to keep people safe.
● A relative raised a concerns that when they visited their family member, they did not always have their call bell close by. They also stated that when they themselves have pressed the call bell, staff have not always responded quickly, and they have had to find a staff member themselves.
● Staff were recruited safely. Relevant checks were completed to ensure staff were suitable to work with people. This included checks of people's identity, qualifications, and criminal record.

Systems and processes to safeguard people from the risk of abuse
● People were not always protected from the risk of abuse and neglect.
● Although people and relatives did not raise concerns with us about their or their family member's safety, due to the significant concerns identified during this inspection, we were not assured that all staff always did what was needed to reduce the risk of people experiencing neglect or coming to harm.
● We discussed the procedure for identifying, acting on and reporting safeguarding concerns with the registered manager. They understood how to report these concerns and records showed investigations were carried out where required. This helped to reduce the risk of people experiencing abuse.
● Care staff received safeguarding adults training, and they understood how to report concerns to the registered manager and to external agencies.

Learning lessons when things go wrong
● The provider had the processes in place to enable the appropriate staff members / management to investigate accidents and incidents and to report them to the relevant authorities.

Visiting in care homes
● There were no restrictions on people visiting this 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 good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- The building was not always used appropriately to ensure people's needs were met.
- We found pieces of large equipment were stored in people's bedrooms. This included hoists/wheelchairs and rotundas. In some bedrooms this posed a significant risk due to the size of the bedrooms and the mobility of people who resided in those bedrooms.
- Some staff spoken with told us it was policy to store equipment in people's bedrooms. We raised this with the registered manager who told us this was not policy and equipment should have been stored in designated storage rooms around the home. This inconsistent approach placed people at risk.
- One person had a wheelchair and stand aid stored in their bedroom that was not theirs. This could indicate that another person's equipment had been used for this person. The registered manager told us this should not have happened, and all equipment should be stored in designated storage areas.
- We noted in one of the lounges a projector screen had been rolled up and pressed against the wall. We were informed by a member of staff that it had been used at the weekend; however, no-one had taken responsibility to put this away. This was very heavy and if it had fallen could pose a risk of harm to people. The provider's failure to ensure safe premises and equipment placed people at increased risk of harm. This was a further breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- People's needs had been assessed prior to them living at the home. However, these assessments did not always result in effective care being provided in accordance with required standards, guidance, and law.
- We saw a person had bruises on their arms. It is good practice to record on a body map where those bruises were to ensure any further bruising could be easily identified and the causes investigated. We found no body map in this person's records. We raised this with the assistant manager and registered manager who confirmed one had not been completed and they did so retrospectively. However, this process should always be in place to reduce the risk of the person coming to further harm.
- A person had been assessed as being able to walk with a walking aid with one staff member but may need a wheelchair for longer 'journeys'. We observed a staff member attempt to verbally force this person into a wheelchair. The person was very resistant to this and made their wishes clear to the staff member. The staff member continued to insist the person used a wheelchair until the assistant manager intervened and the person was then 'allowed' to use their walking aid. We observed this person walking fine with this walking aid. This meant the staff member was either not aware of this person's assessed needs and wishes or had chosen to ignore them.

Staff support: induction, training, skills, and experience
● Staff had received the appropriate training to carry out their role.
● Although staff training was up to date, and staff received regular supervision of their role, we were concerned that staff performance was not effectively monitored. As described throughout this report, we had significant concerns about the performance, attitude, and approach of some of the staff in ensuring all people received safe, effective, caring, and dignified care and support.
● We raised this with the registered manager who told us they were disappointed with the attitude and performance of their staff during this inspection, and, in their view, it did not accurately reflect their normal approach to caring for people. We have reported more on this in the 'Well-Led section of this report.

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to eat and drink enough to maintain a balanced diet
● People told us the food, on the whole was good, and they had choices about what meals they would like.
● We observed lunch being served. This process took over 30 minutes for all people to be sat at their table and then to be served their meal. For some people this meant quite a long wait to be served. However, once people were served, we viewed that most people enjoyed their meals. Some, asked for alternatives to what they were served, and staff accommodated those requests.
● Care records contained guidance for kitchen staff and care staff on how to ensure people with specific dietary requirements and conditions that could affect their health, received their meals in a safe way. This included people at risk of choking and people with diabetes.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People were supported to access external health and social care professionals should there be concerns about a person's health and safety.
● Where people needed support with nursing care at the home this was provided. This included people who required a catheter, support with managing their diabetes and wound care for pressure sores.

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 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.

● We found the MCA and DoLS were being applied appropriately.
● The registered manager had a good understanding of the legal requirements to ensure people were able to express their views, and, where unable, how to obtain appropriate consent for decisions about care.

Inadequate

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

● Staff did not always see people's privacy and dignity as a priority. They did not always understand the need to make sure that people's privacy and dignity was maintained. While this may not be intentional, it resulted in some people not always feeling they were respected or valued.

● We saw a person had a skin tear to their leg and dried blood on their sock. We reported this to a member of staff who advised they had attempted to dress the wound, but the person had refused; records supported this. However, we saw the dried blood remained on the sock all day. We spoke with the person, and they told us they would have liked the sock to have been changed. We checked the person's records throughout the day to see if further attempts had been made to dress the wound and to change the person's sock. We could not see any documentation that any further attempt had been made to support the person to change or dress the wound. This impacted the person's right to dignified care.

● We observed a person in their bedroom wrapped in a quilt with no cover on. They had faeces on them and faeces on their quilt and on the walls. A domestic staff member was working inside the room cleaning their room. They had not raised this with a care staff member. If we had not seen this person and raised this concern the person could have been in this state for a longer period of time. When we returned to their bedroom a cover had been placed on the quilt and pillowcase; however, this was stained with historic blood marks. This person did not receive dignified and respectful care and support.

● We observed a staff member play with the hair at the back of a person's head. The person became very agitated and shouted at the staff member to leave their hair alone. The staff member responded by saying they were trying to fix their hair, and the person again told them to leave them alone. The staff member then walked off without apologising. The person was very agitated and upset by this interaction. The approach of this staff member was disrespectful and uncaring.

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

● People were not always treated well. There was a lack of attention to detail regarding basic elements of care and support from some staff.

● We observed one person with their shoes on the wrong feet. No staff member had noticed this. We observed another person wearing odd socks and a third person with ill-fitting shoes with laces undone which no staff member had attempted to help them with. We tied this person's laces to ensure they did not fall over. These simple but essential elements of how people were dressed were missed by staff.

● People's independence and right to choose were not always encouraged and respected. We observed a

staff member forcibly instruct a person to sit down in a chair when they were trying to walk. The person stated they did not want to sit down, and they wanted to stretch their legs. The staff member was viewed repeatedly stating they must sit down until another staff member stepped in and stated the person could walk if they wanted to. We spoke with the person, and they told us, "I want to walk and they [staff member] are not letting me I need to get strong so I can go home." This person's views were disregarded and the interactions from this staff member were disrespectful and uncaring.

The provider failed to ensure people were always treated with dignity and respect. This was a breach of regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● We did observe some positive interactions between people and some staff. It was clear some staff had a caring, thoughtful, and respectful approach to people's care and support needs. However, this was not reflective of the whole staffing team, and this had impacted on people's experiences of living at this home.

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 as good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

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

- People's personalised care and support needs, choices and preferences were not always met and respected.
- One person told us staff did not use their preferred name. They told us they liked to be called by their middle name, but some staff still continued to use their forename. This person had been at the home for a significant period of time. At lunch we also observed two staff call a person by different names.
- At times, the support provided to people in communal areas appeared rushed and unorganised despite there being sufficient staff in place.
- At lunch we observed a conversation between a staff member and person. The person was trying to tell the staff member that they didn't feel well; however, the staff member kept asking what dessert they wanted and then tried to leave to serve other people. The person then said, "You're not listening to me, I am trying to have a serious conversation with you." The staff member then said the person's GP was due between 2pm and 3pm. If the staff member had spent more time with the person this would have offered reassurance to the person. We heard the person also say they were 'sick of people talking to me like a 5 year old'.
- We noted a person called out for help regularly from their bedroom. We noted on several occasions a variety of staff members walking past this person's bedroom without checking if they were ok. They did not respond appropriately to this person, and this could place the person at risk of harm.
- We noted a person's care plan stated they did not need footplates on their wheelchair as they could 'self-propel'. On the first day of the inspection we noted these footplates were not in place as per the care records. On day 2, footplates were in place, this was despite the assistant manager insisting footplates were never used for this person. This meant the person was at risk of inconsistent care and support.
- We did also observe positive interactions between some staff and the people they cared for. One positive example was when a person at a table at lunch was becoming agitated and started to shout. The staff member came over and reassured the person but also cracked a joke to the other people sat at the table which lightened the mood and made people smile and laugh.

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.

- The provider and registered manager were aware of their legal responsibilities to ensure information such

as care records and policies and procedures could be provided in a format that was accessible to all. This included for people with a sensory impairment such as blindness.

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

● Some people and a relative told us they or their family members experienced loneliness at the home.

● Two people we spoke with told us they felt lonely and would like more company. One of those people said, "I feel quite lonely here. Nobody really talks to me like you [inspector] are now." The second person told us that since they had moved to a bedroom upstairs they felt staff interacted with them less and would like more opportunities to meet people. One person told us religion was very important to them and were worried they may not be able to practice their religion whilst at the home.

● A relative told us their family member said they spent a lot of time on their own and only sees staff when tasks such as laundry, cleaning and food was provided.

● Other relatives praised the staff and felt their family members received sufficient social interaction. They also felt staff were responsive to their family member's needs.

Improving care quality in response to complaints or concerns

● The provider had the processes in place to respond to complaints and concerns.

● Most relatives we spoke with felt their concerns were listened to and acted on appropriately. Records viewed supported this. One relative told us their complaints were always eventually dealt with but did feel the response should be quicker.

End of life care and support

● We found no issues with the provision of end of life support.

● Policies and procedures were in place to support effective and responsive end of life care.

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 good. 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.

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

- There was not an effective process in place to ensure that all people received person-centred care, focusing on always achieving positive outcomes for all people.
- A relative said, 'We would have reservations in recommending Balmore to others. The care can be good on occasions and very poor on others. The lack of consistency is very frustrating, and it seems that we are revisiting the same problems constantly'.
- The registered manager told us they had high expectations of their staff. Throughout this inspection, when concerns were raised about staff performance and in some cases the negative impact this had on people, they told us this was not expected of staff, and they often reported their surprise at the types of concerns we were raising.
- Having observed staff performance over the two days of this inspection it was clear that some staff had lost focus on the requirements of their role; to provide safe, effective, and caring support and care for all people. As stated throughout this report, some people had suffered significant impact on their health, safety, and dignity as a result of poor quality care and support.
- The registered manager and provider had failed in their duty to identify and act on these failings, leading to poor outcomes for some people.

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

- The provider had failed to ensure all staff had a clear understanding of the requirements of their role, both in terms of the quality of their performance and how to reduce the risks to the health and safety of the people living at the home.
- Reviews of staff performance were completed but were ineffective. Senior staff did not receive a robust review of their performance which has contributed to the significant failings in terms of the management of people's medicines. People have been placed at significant harm as a result.
- Quality assurance procedures were in place; however, these were ineffective. There were audits in place for infection control, medicines and pressure relieving equipment. All of which had failed to identify the significant failings in these areas, all have resulted in people being placed at increased risk of significant harm and impacted their health and safety.
- Where responsibility for completing audits had been delegated from the registered manager to other staff, reviews of the quality of those audits had either not been completed, or, where they had, had failed to address their quality.

● For example, the audit for pressure relieving cushions for August, September and October 2023 had all been completed incorrectly. The audits had actually stated that there were issues with these cushions; however, it was evident that the person who completed the audit had not read the questions correctly, ticking 'yes' to all questions. This meant every pressure relieving cushion within the home would have been unusable. This was not the case. A review of those audits had also failed to identify the error meaning this audit was incapable of identifying concerns relating to people's pressure cushions. This could result in people experiencing avoidable harm.
● The registered manager had received limited support to develop their role and to help them to identify risks and concerns throughout the home. An internal provider-led audit commenced in January 2023. This was not fully completed, and the registered manager had received no feedback or further audits in that time. The failure to carryout robust quality assurance has contributed to the increased risk to people's health and safety.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Staff had not been fully involved or monitored to ensure that people received safe, effective, and caring support and care.
● We were concerned that things we had identified during this inspection had not been identified by the registered manager, but also the numerous senior staff they had working with them. Senior staff had all failed to identify any of the serious and significant risks we had identified during our inspection. When we raised concerns with some staff and senior staff we were given incorrect information and in some cases were reluctant to accept our findings. This raised significant concerns about the culture within the staffing team as a whole.
● The registered manager told us they and/or the assistant manager did a daily walkaround the home to help them to identify any concerns and they would then report this to the relevant staff in the relevant department to take action. There were no records in place to support this process.
●We were informed by the operations manager that there was an expectation that the registered and assistant managers would meet with heads of department to discuss any concerns or risks. The registered manager told us this had not occurred. This meant there had been a failure to engage and involve staff in identifying risk and acting on it, resulting in an increased risk of harm to people.
● A survey had been sent to relatives of people living at the home in June 2023. 51 surveys were sent with just 4 responses received. Although the results were analysed this would not give the provider sufficient feedback on the positive elements at the home and areas for improvement.

The provider's failure to ensure robust and effective governance procedures placed people at increased of harm. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Surveys for staff had recently been sent out but feedback not yet received. There had not yet been any form of survey (or alternative format) to obtain the formal views of people living at the home.
● Three of the 4 relatives we spoke with gave positive feedback about the care provided and the management of the home.

Working in partnership with others
● The provider worked with other agencies and health professionals when discussions and decisions were needed about the care and nursing needs for people.

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 their legal requirement to ensure that where mistakes were made they apologised to those affected.

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 Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider's failure to ensure people were always treated with dignity and respect. This was a breach of regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider's failure to ensure the safe management of people's medicines placed people at increased risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider's failure to ensure the safe infection control practices placed people at increased risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We have imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment
Treatment of disease, disorder or injury	The provider's failure to ensure safe premises and equipment placed people at increased risk of harm. This was a breach of regulation 15(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We have imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider's failure to ensure robust and effective governance procedures placed people at increased of harm. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The enforcement action we took:

We have imposed conditions on the provider's registration.