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Broxbourne House

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

Summary of findings

Overall summary

About the service
Broxbourne House is a residential care home providing personal and nursing care to 21 people aged 65 and over at the time of the inspection.

Broxbourne House accommodates people in one building. Communal areas are situated on the ground floor. Accommodation is provided on the ground and first floor. At the time of the inspection 21 people were using the service.

People's experience of using this service and what we found
People were not safe. Risks to individuals were not assessed and appropriately managed. Medicines were not managed safely. There were insufficient staff with the appropriate skills and knowledge to meet people's needs and keep them safe. Recruitment practices were not robust and did not ensure staff were suitable to work at Broxbourne House. Lessons were not learned when things went wrong.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. New staff did not receive appropriate training which meant they were not equipped with the relevant knowledge and skills. People's experience at meal times varied. People were generally complimentary about the food although some felt there was limited choice. Systems were in place to support people with their health needs. The design of the building meant people had limited space to use. The environment was not decorated to a good standard.

People were not treated with respect and their privacy and dignity was not maintained. Most people did not have their own toiletries and there were no towels, wipes or cloths in people's rooms. People were often shaved and changed into their nightwear in the bathroom or shower room rather than their own bedroom. Towels, face cloths, duvet covers, pillowcases and sheets were all piled in a cupboard in a bathroom. These were worn, discoloured and some were torn although were replaced when we raised a concern with the registered manager. Some individual staff showed kindness and compassion. Feedback about staff and the care people received was mostly positive.

People did not receive person-centred care because daily routines were task orientated and determined by staff with little choice being offered to people. People were up early, went to bed early and their meals were served early. People's care needs were not identified, recorded, and highlighted in care plans. People sat for long periods with no stimulation and activities were not planned. People were supported to maintain relationships with family and friends; visitors told us they were welcomed. The provider had a system for dealing with complaints and concerns. A concerns record showed when issues were raised they were dealt with appropriately. Action was taken to investigate and resolve the concern.

The provider's quality management systems were not effective and did not identify areas where the service

had to improve. The provider and registered manager did not demonstrate they understood their responsibilities and accountability. People who used the service, relatives and staff provided consistent positive feedback about the registered manager and provider. A health professional told us always had opportunity to speak with the registered manager.

The provider sent an action plan after the inspection which showed they were addressing concerns raised by CQC.

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 24 March 2017).

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement
We have identified breaches in relation to staffing and staff training, person-centred care, treating people with dignity and respect, assessing and managing risks to individuals, management of medicines, recruitment of staff, supporting people around consenting to care, governance, safeguarding people from abuse and failure to notify CQC about significant events.

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 referred our concerns to the local safeguarding authority and asked the provider to send us further evidence of improvements. We will meet with the provider to understand what they will do to improve the standards of quality and safety. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

If 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 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?

Inadequate

The service was not 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.

Broxbourne 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 Care Act 2014.

Inspection team
Two inspectors and an Expert by Experience carried out the inspection. 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
Broxbourne House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from Healthwatch and the local authority. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with six people who used the service and four relatives about their experience of the care provided. We spoke with a visiting health professional and ten members of staff including the registered manager, deputy manager, senior care worker, care workers, laundry worker, domestic and cook. The provider was on leave at the time of the inspection.

We reviewed a range of records. This included five people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff training. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the registered manager to validate evidence found. We looked at policies, quality assurance records and action plan sent to us after the inspection.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- Risks to people were not appropriately assessed or managed which placed them at risk of harm or injury.
- Unexplained injuries were not investigated. Body maps were completed when staff observed injuries such as bruising and skin tears. However, there was no follow up to establish possible causes.
- One person was assessed as high risk of consuming dangerous substances and their risk assessment stated 'staff must ensure all cleaning products are stored in a cupboard and locked at all times'. All toiletries had been removed from their room. However, during the inspection the domestic store cupboard and sluice room, where bleach was stored, were left open. Bottles of antibacterial handwash were available in every bathroom, including the one next to the person's bedroom. Another person had experienced two falls one of which resulted in a serious injury. However, their falls care plan made no reference to the falls and provided no guidance for staff about how to keep the person safe.
- People's weight was monitored, but the service was not responsive when people lost weight. One person had lost over 11kgs in six months; their nutritional risk assessment was not dated, and they had no nutritional care plan.
- Moving and handling practices were not safe. Staff were observed using different techniques and equipment to support people when transferring them from chair to wheelchair. However, assessments did not provide sufficient detail to ensure people were moved safely. One member of staff who was new in post tried to stand one person from the chair. A member of the catering team advised they needed two staff.
- Care records stated staff should assess people before carrying out transfers. The registered manager said staff had not completed training which equipped them to assess people's moving and handling needs.
- A member of the management team said people had their own sling which was assessed as suitable to transfer the person safely. However, staff were using the incorrect sling for one person.

The lack of identifying, assessing and managing risk meant people were not safe. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded after the inspection. They sent us an action plan and told us they were improving how they identified, assessed and managed risk.

- Checks had been carried out by external contractors to make sure the premises and equipment were safe.

Staffing and recruitment

- There were insufficient staff with the appropriate skills and knowledge to meet people's needs and keep them safe.

● Several of the accident and incident reports showed people had fallen when staff were not present. On occasions, other people living in the home had sought out staff to inform them that a person had fallen or required help.
● Staff were not always aware of people's needs. We observed a staff member who had not received an induction and did not know people's needs, but was providing support to people, sometimes unsupervised.
● Mixed feedback was received about the staffing arrangements. Some people told us there were enough staff others felt there should be more. One person said, "They seem to be permanently short of staff." A relative said, "Sometimes the buzzers go and no one comes, usually they are always going off, not today though…maybe because you are here."

The lack of sufficient, competent staff meant people were not safe. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Recruitment processes were not safe.
● Not all required checks were completed before new staff started working in the service.
● A criminal record check had not been completed for one staff member. Although the registered manager addressed this when we brought it to their attention, they were not aware the check had not been done.
● References had been obtained however it was not always clear in what capacity the referee knew the person or where the referee was employed. The registered manager confirmed none of the references had been verified.

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

The provider responded after the inspection. They sent us an action plan and told us they were improving their recruitment process.

Using medicines safely
● Medicines management was not safe.
● Where people were prescribed 'as required' medicines, there were not always protocols in place to guide staff.
● People did always receive their medicines as prescribed. One person had a medicine which should have been given with a four-hour gap between doses. The medicine administration record showed this medicine was being given twice a day with only a three-hour gap. The registered manager said this had been agreed with medical professionals, but was unable to show us any records confirming these discussions or tell us when this had been agreed.
● One person was prescribed a medicine where the dose varied according to blood test results. We were unable to check that previous doses had been given correctly as no records were kept of the blood test results.
● Medicine administration records were generally well completed although handwritten entries had not been signed by two staff members. Where changes or amendments had been made these were not always recorded accurately.
● Some people had topical creams, but records which showed when and where the creams should be applied were not always available.

The lack of managing medicines appropriately meant people were not safe. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded after the inspection. They sent us an action plan and told us they were improving medicine practices.

● Medicines were stored safely and securely. Staff who administered medicines had received training and had their competency assessed.

Learning lessons when things go wrong
● Accidents were not always appropriately recorded which meant the management team did not determine if there were any lessons to be learned.
● The provider did not have an accurate overview of accidents and incidents that occurred so did not identify if there were any patterns and trends.

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

Systems and processes to safeguard people from the risk of abuse
● People were not protected from abuse because safeguarding procedures were not followed.
● Records showed incidents of abuse and allegations of abuse had occurred, but these were not referred to the local safeguarding authority. CQC were not notified about abuse which meant we were unaware of significant events and did not have relevant information about how the provider had responded.
● Management and staff knew they should, but did not always report, incidents of abuse and allegations of abuse to other agencies.

Failure to follow safeguarding procedures meant people were not protected from abuse. This was a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the inspection we shared our concerns about people's safety with the local safeguarding authority.

● People told us they felt safe. One person said, "Yes I feel safe here; nobody would harm me." Another person said, "I'm happy here. I feel safe." One relative said, "Yes she is safe I have no reason to doubt it no risk of harm at all." Another person said, "I think [name of person] is safe, they have fallen out of bed trying to get to the commode. They are not allowed to go to their room on their own because of falls and once they tried to climb stairs which is unsafe."

Preventing and controlling infection
● Systems were in place to prevent and control infection.
● The service looked clean and no odours were noted. Bathrooms and toilets were stocked so appropriate hand hygiene procedures could be followed.
● Staff followed infection control procedures by wearing appropriate protective clothing and received infection control and food hygiene training.
● An infection prevention and control practitioner had recently audited the home and were in the process of completing the paperwork. They told us, 'The score was very good and there were only a few action points which were in relation to the cleaning of equipment." The local authority safety and health protection team told us, "Our food team visited recently and found no issues of concern relating to food hygiene."

Requires Improvement

Is the service effective?

Our findings

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

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

Staff support: induction, training, skills and experience
- Staff did not receive the induction, training and support they required to fulfil their roles.
- Staff completed a workbook but did not receive any formal induction or training when they commenced in post.
- The registered manager said new staff shadowed an experienced staff member. However, one staff was working unsupervised on their first day.
- One recently employed staff member had no induction records and confirmed they had received no formal training since starting in post. They said they had not been shown the fire procedures or received any fire safety training.
- The registered manager told us staff did not complete the Care Certificate as they only employed staff who had previous care experience. However, one staff member had no previous care experience and no evidence of any qualifications in care.
- Staff received annual training which covered topics relevant to their role. However, the training was delivered to all staff and provided at the same time each year. This meant staff who started working at the home after the training had been delivered would have to wait several months.

The lack of support meant staff were not enabled to carry out their role competently. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded after the inspection. They sent us an action plan and told us they were improving how staff were supported.

- Staff who were not new to their post told us they had received training. One member of staff said, "My training is all up to date. We did face to face and covered things like first aid, capacity, safeguarding, manual handling and a bit on medication." Another member of staff said, "We do annual mandatory training which covers everything like safeguarding, mental capacity, health and safety, moving and handling. We do it over two or three days.
- Staff told us they felt well supported by the management team. They said they received regular supervision where they had chance to talk to about things that were relevant to their role.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible,

people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

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

● People were not always appropriately supported to have choice and control of their lives because the key principles of the MCA were not applied.

● Decisions made on behalf of a person were not always recorded to show these were in their best interests. On day one of the inspection we noted one person's clothing had been removed from their room. Staff said this was because they would remove all items from the wardrobe, however, there was no reference to this in the person's care records. We raised concerns about this practice with the registered manager.

● Capacity assessments and best interests decisions were sometimes completed but other relevant people were not consulted. For example, one person had an undated best interests decision record for use of a door alarm; only two members of staff had been involved.

● One person had a capacity assessment for personal care which showed they had capacity. However, there was no evidence to show they had consented to or been involved in planning and reviewing their care.

Failure to apply the principles of the MCA meant people and their representatives did not have choice and control of their lives. This was a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during and after the inspection. When we returned on day two, the person's clothes had been returned to their room and a lock had been fitted to the wardrobe. Their care records had been updated. The provider sent us an action plan and told us they were improving how they supported people who lacked capacity.

● The provider sought authorisation when people were deprived of their liberty. The registered manager maintained a record to make sure any specific conditions were monitored and met.

Supporting people to eat and drink enough to maintain a balanced diet

● People enjoyed their lunch and were generally complimentary about the food. Some felt there was limited choice, but foods would be provided if they wanted an alternative. One person said, "I have no real complaints about food, I don't like jelly, so I get a choc ice instead. There is a limited choice but if I ask for anything I get it". A relative said, "They have a very good cook who is always asking them what they want."

● One person said they had recently experienced the provider purchasing provisions that were requested. They told us, "I said I liked blue cheese and well, the next day I had blue cheese. Another time I said I liked green olives and [name of provider] brought me some in."

● People's dining experience varied, and sometimes depended on the approach of individual staff. During breakfast a member of staff provided dedicated time to one person who required support to eat. Other people did not receive one to one support. Some people were not asked what they wanted to eat.

● One person had their food blended. The meal was well presented; each food was blended separately so the person could enjoy different tastes.

● A member of the catering team asked everyone if they had enjoyed the meal and offered additional portions. They appeared to know people's likes and dislikes. They checked people were ready for dessert before they started serving. Throughout the meal the member of the catering team was polite, courteous and took time to chat. It was evident from people's responses they knew the member of catering staff well and enjoyed the interaction.

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

● The design of the building meant people had limited space to use. The lounge was often overcrowded. We were sometimes unable to sit with people and chat because there was no space. A relative said, "The lounge is cramped and we are unable to hold a proper conversation so we go to their room for a private chat. It's not got a lot of space to wander about for [name of person]."

● The environment was not decorated to a good standard. Redecoration had commenced; some bedrooms had been painted. New easy chairs had been purchased.

● There was a lack of personalisation in some people's rooms. Others had photographs and personal items. Two rooms were shared; privacy screens were provided in both rooms.

● The management team were aware the environment needed to improve. They said improvements would continue.

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

● People's care records showed they received support to make sure their health needs were met. Appointments with health professionals were recorded, such as district nurses, GPs, chiropodists, optician, rapid access team.

● A visiting nurse practitioner told us contact from the service was appropriate. They told us, "I've no concerns about the care. They call when necessary and communicate well with families."

● People told us other professionals were involved in their care. One person said, "We get help from others if we need it such as the optician."

● Staff were confident other agencies were involved in people's care and advice was appropriately sought. During a handover meeting staff discussed concerns about two people's health; a member of the management team promptly requested support from the relevant health professionals.

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

● The registered manager said people's needs were assessed before they started using the service.

● Care recording was being transferred onto an electronic system. The management team explained that daily notes were recorded electronically and all other care records were paper based. We saw the work to transfer the care records was in progress.

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 the last inspection this key question was rated as good. At this inspection this key question has deteriorated to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care

- People were not treated with respect. Most people did not have their own toiletries; a member of the management team showed us a cupboard in the laundry which had communal body wash, shampoo and body spray. They said these items were used for people. Unnamed, used hair brushes were also stored in the laundry cupboard. Men's shaving equipment was sometimes kept in the office. Two people who shared a room had toothbrushes, but these were in the same container. The member of staff who showed us around did not know which toothbrush belonged to which person. Staff confirmed people were often shaved in the shower room, and on an evening were changed, in the bathroom or shower room, into their nightwear.
- Most people did not have essentials for washing in their room. There were no towels, wipes or cloths. A member of the management team said night staff took towels and cloths into the room when they were getting people up on a morning and then put them straight into the laundry.
- People did not have matching bedding and pillowcases. Bedding and towels were worn, discoloured and some were torn; towels, face cloths, duvet covers, pillowcases and sheets were all piled in a cupboard in a bathroom.
- Some individual staff showed kindness and compassion, but general practices were not respectful and did not support independence. For example, at breakfast, tea was the only hot drink offered. A staff member took round a huge teapot filling up people's cups and then came around and put sugar in cups and stirred it. Only one person was given a mug of tea and brought a milk jug and sweetener, so they could help themselves. A huge bowl of porridge was used to serve porridge into bowls and then sugar was sprinkled on top. Only four people were offered a choice; cornflakes or porridge.
- People's privacy and dignity was not always respected. Some staff were sensitive and discreet when asking people about their personal care needs, however others were not. We heard staff in communal areas asking people in loud voices about their continence needs.

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

- Staff told us they had not read some people's care plans. One member of staff said, "It my goal to get through everyone's care plan, I don't have enough time to do that. It's a good idea to know about the people you are looking after, now we find out through handover."
- Staff practices varied. Negative interactions were observed when staff were not caring or considerate to people. One member of staff assisted a person to eat their breakfast. They did not speak to the person and just spooned the food into their mouth and wiped food from the person's mouth using the bottom of the clothes protector. They then attempted to give the person a drink while the person's mouth was still full of

food. Some people were given spoonfuls of food by different staff as they were walking past.

The lack of care and compassion people experienced meant they were not treated with dignity and respect. This was a breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during and after the inspection. They purchased new bedding and towels. The provider sent us an action plan and told us they were improving care practices.

● Positive interactions between staff and people included, staff offered and covered a person with a blanket to keep their legs warm and staff explained what they were doing when transferring a person from a chair to a wheelchair using a hoist. They reassured the person throughout and ensured the person's clothing was adjusted to maintain their dignity. A member of the catering team was particularly good when interacting. They spent time chatting to people and checking people were ok. At lunch one person was tapping their plate. Care staff in the dining room had not noticed the person could not reach food on the other side of the plate. The catering staff intervened and discreetly turned the person's plate around.
● Feedback about staff and the care people received was mostly positive. Comments included, "Staff are good I can't complain. If I wasn't satisfied I wouldn't be here", "Staff are good to me, they look after me", "Staff look after me well" and "Staff are very good at helping, they give me a shower at least once a week." Less positive comments were, "Some staff are lazy and don't do things properly" and "The staff are generally good, one or two are excellent but others are not so good".
● Relative comments included, "Care is very good; they couldn't do any better" and "Staff are very friendly. They call [Name of person] by her name, ask if she is ok and always check its ok to do anything before they do".
● People's care records had information about their background, history, likes and preferences although this was usually basic. For example, one person's record stated their 'role is being content and happy' and 'I don't have any pets and I'm unable to express how I feel about animals' and 'I do not follow a religion'. There was reference to two family members, but it did not say if they had contact or were involved. Another person had more specific detail, for example, 'my wife is very important to me' and 'I am interested in cars and like to chat about them' and 'I enjoy watching sport and enjoy all types of music'.

Inadequate

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to inadequate. This meant services were not planned or delivered in ways that met people's needs.

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

- People did not receive person-centred care. Staff routines took priority over people's preferences and individual needs.
- Daily routines were task orientated and determined by staff with little choice being offered to people. People were up early and went to bed early. Meal times were also early.
- When we arrived at 8am on the first day of the inspection everyone was up, dressed, had finished their breakfast and were sat in the lounge. The registered manager told us this was people's choice and they were all 'early birds'. At the end of the first day, we shared concerns about the task orientated routines. However, on the second day of the inspection we arrived at 7am and 16 people were up in the communal areas. Some were sat at the dining table with clothes protectors on waiting for breakfast.
- Staff described routines which were the same each day and not person-centred. For example, people were toileted at the same time and in the same order. One member of staff told us one person, who shared a room, woke at 4am each morning so they were assisted to get up. They said the person they shared with also woke up so night staff assisted them to get up too.
- Staff said lunch was usually served at 11.30am and tea time was 4.30pm.
- On the first day of the inspection, everyone was taken to the dining room for lunch but waited for over 30 minutes before the meal was served. Everyone wore a blue clothes protector. Three people were asleep as they waited for their meal.
- People's care records were not personalised or up to date and did not reflect their current needs or the support they required from staff. Many of the care plans lacked detail and were pre-printed with standard sentences such as 'likes to have a bath/shower at least once a week'. There was no information about whether the person preferred a bath or a shower, when they preferred to bathe, and if they required any equipment or support from staff.

Failure to provide appropriate care and the lack of designing care meant people's needs were not identified and met. This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during and after the inspection. The provider sent us an action plan and told us they were reviewing care records and practices to ensure the care was person-centred.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to

follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● People's communication needs were not appropriately assessed. Everyone had a standard statement about accessible information at the front of their file, which explained people's communication and information needs should be identified. However, the individual detail provided alongside the explanation sheet did not ensure people would receive information in a way they could understand. For example, one person's record stated they could retain information but said the best way to contact them was by letter or phone.

The lack of designing care meant people's needs were not appropriately identified. This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● A member of the catering team used pictures to help people to choose what they wanted for lunch. The management team said they used pictures to show people what foods were available but generally information, such as, policies and procedures were only available in a standard format. They said they had more work to do in this area and would be looking at alternative formats such as easy read and pictorial to help ensure people's communication needs were 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
● Social activities did not meet people's individual needs. During the inspection people sat for long periods with no stimulation.
● People and their relatives told us opportunities to take part in activities was lacking. Comments included, "The only stimulation is watching the TV", "I read a book. There is not a lot to do", "Nothing to do". One relative said, "My husband is down in the dumps; his social skills are deteriorating. There is a lack of interaction, he's very bored."
● The registered manager told us the activity co-ordinator was absent from work so activity provision had been limited. They said they did not have any activity plan and did not plan in advance.

The lack of opportunity for people to take part in activities meant people's needs and preferences were not met. This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded after the inspection. The provider sent us an action plan and told us they still did not have an activity coordinator, 'so an activity planner had been made and one staff was assigned to do activities on a daily basis based on the planner'. They did not explain if an additional member of staff was providing the activities or staff on shift were fulfilling this role.

● The registered manager said, "We have one trip out a year; we went to Bridlington on a coach this year." One person said, "I enjoyed the trip out."
● Relatives told us they were made to feel welcome and were kept up to date. One relative said, "They discuss any changes with me, if [name of person] has any falls they ring me straight away and let me know if they are going to hospital or if I need to come to the home. They are very good that way." Another relative said, "Visiting is 8am to 8pm, but they let me come any time. I've even been here at 2am when [name of person] came back from hospital."

End of life care and support

● The service did not engage people in planning their end of life care or record their wishes.
● The registered manager said they had not explored people's preferences and choices in relation to end of life care. They said, "We have no end of life care plans for people."
● Although no one was receiving end of life care at the time of our inspection, the provider notified us soon after the inspection that one person had died. They had also notified us of two other deaths in 2019.

Failure to involve people in planning their end of life care meant people's preferences were not reflected. This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded after the inspection. The provider sent us an action plan and told us they were introducing a process for involving people and recording their wishes for their end of life care.

Improving care quality in response to complaints or concerns
● The provider had a system for dealing with complaints and concerns.
● The registered manager said they had not received any formal complaints although they recorded concerns and four had been received in 2019.
● The record showed people's concerns were taken seriously and dealt with appropriately. Action was taken to investigate and resolve the issue. The registered manager had recorded where people were happy with the outcome and actions taken to prevent repeat events.
● People who used the service and relatives provided consistent feedback that the registered manager and provider, who they said spent a lot of time at the service, would deal with concerns. One person said, "[Name of provider] does listen and does do things when you ask him." A relative said, "I've never had any complaints, but [name of provider] would sort it straight away."

Inadequate

Is the service well-led?

Our findings

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

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

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

- Widespread and significant shortfalls were identified at the inspection. The provider was in breach of nine regulations; the service has been rated inadequate overall.
- Quality management systems were not effective. There was a lack of monitoring by the management team and provider. The provider's auditing and monitoring processes were not effective and had not highlighted issues that were raised at the inspection.
- The management team did not have a clear overview of what was happening in the service. They did not know how many accidents and incidents had occurred because their analysis was not accurate. For example, the analysis for July 2019 showed only two accidents had occurred, yet there were seven accident reports. There were similar discrepancies in the analyses for May and August 2019.
- The provider was visible and spent a lot of time at the service, but they did not complete any monitoring report or record.
- Accountability arrangements were unclear. The management team said areas for improvement had been identified such as staff training, and these had been shared with the provider. However, there was no evidence to support this.
- The provider had policies and procedures, but these were not always followed. For example, their recruitment policy stated, one reference must be from the last employer. Their safeguarding policy stated they would act promptly in the event of suspected, imminent or actual abuse, informing other agencies including CQC and the local authority. During the inspection we found these practices were not followed.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes 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 service was not well led. The registered manager and provider did not provide leadership which promoted high quality and personalised care.
- Staff did not understand that people's preferences and individual needs should take priority over staff routines. Staff did not always refer to people appropriately. For example, they routinely referred to people who required support from two staff as "doubles".

- The lack of robust quality assurance meant people received poor quality care. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded after the inspection. The provider sent us an action plan and told us they were putting a system in place to promote effective management.

● Notifications about some significant events had been submitted to CQC. However, we identified nine serious injury and safeguarding notifications which were not received.

Failure to submit required notifications meant CQC were not made aware of multiple significant events and did not have relevant information about how the provider had responded. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Registration) Regulations 2014.

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

● People who used the service, relatives and staff provided consistent positive feedback about the registered manager and provider. Comments included, "The manager seems to be on the ball and seems to know what people need", "[Name of provider] the owner is really good with people" A health professional told us always had opportunity to speak with the registered manager.

● A resident and relative meeting was held in July 2019 and was attended by the registered manager and provider.

● Staff said they attended meetings and had opportunity to discuss the service. The registered manager said meetings were held in June, August and September 2019. The meeting minutes from June were available. Only brief notes from the August and September meetings were available, for example, 'need more staff'. The notes did not include attendees or a clear overview of what was discussed. This meant anyone who did not attend the meeting did not have access to information about what was agreed.