Sanctuary Care Limited

Bartley Green Lodge Residential Care Home

Inspection report

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14 February 2018
21 February 2018

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This unannounced comprehensive inspection took place on the 13, 14 and 21 February 2018. The inspection was prompted in part by increased statutory notifications from the registered provider. From those notifications we identified some vulnerable people were not being adequately safeguarded. The notifications indicated potential concerns about the management of people's care needs. This visit was also brought forward following information of concern being shared with us by the local authority. This inspection examined those risks.

Bartley Green Lodge Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Bartley Green Lodge accommodates up to 47 people in one adapted building comprising of three units, two of which specialise in caring for people living with dementia. At the time of our inspection 44 people were living at the home.

Since our previous inspection in November 2016 we have reviewed and refined our assessment framework, which was published in October 2017. Under the new framework certain key areas have moved, such as support for people when behaviour challenges, which has moved from Effective to Safe. Therefore, for this inspection, we have inspected all key questions under the new framework, and also reviewed the previous key questions to make sure all areas were inspected to validate the ratings.

At the last inspection in November 2016, the service was rated Good but required improvement in the key question, 'Is the service Safe?' We identified issues around the management of medicines and the management of risks to people.

At this inspection of February 2018 there was not a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider had recently appointed a new home manager who was undertaking their induction. The home manager was present throughout our inspection.

During this inspection in February 2018 we found significant shortfalls in the service. We found examples of where people had been exposed to actual harm and abuse and staff had failed to protect people from future occurrences. We were so concerned about our findings that we made immediate contact with the local authority to discuss the shortfalls and we used our urgent enforcement powers to ensure the registered provider took immediate action to ensure the safety of people who had been identified as at high and extreme risk of harm.

People were not protected from harm due to staff not recognising and reporting safeguarding incidents to the local authority. We found there to be insufficient numbers of staff working at the service to keep people

safe. People were not receiving the levels of supervision they needed. People had experienced and were at risk of experiencing unsafe care and support as a result. People did not always receive their medicines as prescribed.

People were not supported by care staff that had the training, skills and knowledge to support them effectively. Staff had received safeguarding training but still failed to recognise abuse and had failed to escalate and follow processes. People were not supported in a way that protected them from unlawful restrictions due to staff lack of understanding and knowledge of the Mental Capacity Act. People did not have their fluids intake managed safely when it had been identified that they were of risk of dehydration. People were supported to see healthcare professionals for routine appointments or when a change in their health was identified.

Although staff were caring in their interactions they had not recognised the need to protect people from potentially abusive situations and did not appear to recognise the severity of the situation. Staff did not have time to spend with people and missed opportunities for interaction. Staff were focused on tasks and people did not receive care that was responsive to their individual needs. People's privacy and dignity were not always respected.
People did not receive personalised care which met their needs. People were not supported to access hobbies and activities and supported to choose how they spent their time. People knew how to complain and processes were in place to manage concerns and complaints.

There was inadequate monitoring in place at the service and this had resulted in poor outcomes for people. People had been placed at risk of significant harm and some had experienced harm which could have been prevented. Ineffective quality monitoring systems had failed to pick up and address the failings we identified during our inspection and as a result people had been exposed to harm. In addition the registered provider had failed to notify us of events as required by law.

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

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question of overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

We found that the provider was not meeting all of the requirements of the law. We found multiple breaches in regulations. You can see what action we told the provider to take at the back of the full version of the

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. We have taken urgent enforcement action to impose immediate conditions on the registered provider's registration in order to protect people's safety and well-being.

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.

The service had failed to safeguard people. Risks had not been assessed and managed to reduce the risk of avoidable harm.

Information available about people's needs and dependencies was not used to accurately review and revise staffing levels.

People did not always receive their medicines as prescribed.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always supported by staff who had training in how to meet their specific needs. Staff training had not always been embedded into practice.

People received support to eat, however records did not always show that people were drinking sufficient amounts of fluid when needed.

People were asked for their consent before care and support were provided, however, staff lacked knowledge about supporting people in ways which didn't restrict their freedom.

People were supported to see external healthcare professionals when required.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staffing levels meant that staff were more focused on tasks than people and their well-being.

People did not consistently have their privacy and dignity respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The care provided was not person-centred and did not always meet people's individual needs and preferences, including the provision of activities.

People and their relatives knew how to raise a complaint.

Is the service well-led?

Inadequate

The service was not well-led.

There were no effective systems or processes in place to ensurethat the service was safe, effective, caring, responsive or well led.

The registered provider failed to protect people from unsafe care and as a result people had experienced inadequate care and support.

The registered provider failed to notify us of incidents as required by the law.

Bartley Green Lodge Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This unannounced comprehensive inspection took place on the 13, 14 and 21 February 2018. The inspection was prompted in part by increased statutory notifications from the registered provider. From those notifications we identified some vulnerable people were not being adequately safeguarded. The notifications indicated potential concerns about the management of people's care needs. This visit was also brought forward following information of concern being shared with us by the local authority. This inspection examined those risks. The inspection team consisted of three inspectors and an expert by experience on the first day, one inspector and one pharmacist inspector on the second day and one inspector on the third day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

We had already asked the provider to complete a Provider Information Return (PIR) earlier in 2017, so we did not ask them to complete this again. A PIR is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this information into account when we made the judgements in this report. We also reviewed the information we held about the service. We looked at information received from the local authority commissioners, Healthwatch and the statutory notifications the manager had sent us. Commissioners are people who work to find appropriate care and support services which are paid for by 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 all this information to plan what areas we were going to focus on during our inspection visit.

During our inspection visit, we met and spoke with 11 of the people who lived at the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us. We observed care and support being delivered in communal areas and we observed how people were supported to eat and drink at lunch time. We spoke with 11 relatives of people and one visiting care professional to get their views. In addition we spoke at length with the regional manager, the care development manager, the home manager, three senior care assistants, the cook and seven care assistants.

We reviewed five people's care plans and daily records to see how their care and treatment was planned and delivered. We looked at how medicines were managed by checking the Medicine Administration Record (MAR) charts for 12 people. We checked whether staff were recruited safely, and trained to deliver care and support appropriate to each person's needs. We reviewed the results of the provider's quality monitoring system to see what actions were taken and planned to improve the quality of the service.

Inadequate

Is the service safe?

Our findings

At our last inspection in November 2016 we rated the registered provider as 'Requires improvement' in this key question. We found that people were placed at risk by the lack of clear systems and records to ensure that people who needed support received their prescribed medication as directed. Risks to people were not always reflective of their needs.

At this inspection of February 2018 we found that the issues had not been addressed and the service had deteriorated. The provider had failed to ensure people received consistently good, safe care that was compliant with the legal regulations.

People living at Bartley Green Lodge were not receiving safe care and support and were placed at risk of harm. We identified serious concerns around the registered provider's ability to effectively assess and manage the risks to people who used the service. These included how staff supported people to manage risks associated with their behaviour, staffing levels in the service and how medicines were being managed. We found examples of where the registered provider had failed to keep people safe. We also found examples of where people had been exposed to actual harm and staff had failed to protect people from future occurrences.

The registered provider had failed to ensure staff had the appropriate knowledge and understanding to protect people from abuse and recognise when safeguarding referrals needed to be made. Staff lack of knowledge around safeguarding people meant that they had not recognised or responded appropriately to known abuse. As part of our inspection we reviewed care records and found seven incidents of abuse. There had been no investigations into incidents and no safeguarding referrals had been made to protect people who lived at the home from the risk of further abuse. We identified that the registered provider and staff had failed to recognise the abuse people had experienced at the service. During day one of the inspection we instructed the registered provider to immediately put in place control measures which would improve people's safety. We returned to the home for a third day to see if immediate improvements to known risks had been met. We found that the control measures that had been put in place to mitigate risk had failed to do so. In response to our concerns the registered provider arranged for urgent safeguarding training for all staff and we were advised that all incidents had retrospectively been reported to the appropriate safeguarding agencies.

People had not been protected from the risk of abuse and improper treatment and systems had not been established to prevent the risk of abuse. This constituted a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment.

The registered provider had failed to ensure there was an effective system in place to ensure risks were monitored and managed in order to protect people from avoidable harm. Risk management plans for one person who had a history of inappropriate behaviour that presented a risk of harm to other people did not give staff sufficient information and guidance about how to support the person appropriately. Assessments

to identify these risks were either insufficiently detailed, or was not being followed by staff. For example, the person's risk assessment identified they were to be monitored in communal areas and a door sensor alarm should be used to monitor the person's whereabouts. However we found the person unsupervised in the communal lounge area and some staff did not know how regularly they should check the person. We identified that the door sensor alarm was not active and had been disconnected. Staff and managers we spoke with did not know why the alarm had been disconnected. This was evidence that this risk was not being effectively managed. This meant the person continued to be a risk to themselves and others.

Records showed that people who lived at the home had risk assessments in relation to their specific conditions however these were not always followed by staff. In one instance, the care plan for a person who was at risk of developing pressure sores did not state how frequently staff should support the person to reposition to improve their skin integrity. The daily records completed showed that this support was not consistently provided to ensure that the persons' health and well-being was maintained. We found from records completed by staff that repositioning intervals varied from two hours to four hours. This practice placed people at the risk of harm.

One person we spoke with told us, "They [the staff] never forget to give me medication." We looked at how medicines were managed by checking the Medicine Administration Record (MAR) charts for 12 people, speaking to staff and observing how medicines were administered to people.

We looked at the records of two people who were administering some of their medicines independently. We found a risk assessment had been completed, however we found that systems were not in place to monitor this and therefore the service could not be sure that these medicines were being administered as they had been prescribed.

Controlled Drugs were not administered as prescribed and the systems were unsafe. Controlled Drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse. We looked at the controlled drugs administration records and found that the analgesic skin patch application intervals were not being adhered to. For example, the analgesic skin patches for one person were supposed to be changed every seven days to provide continuous pain control but we saw on two occasions the patch was not changed for 14 days. We also saw for another person on three consecutive occasions a different type of analgesic patch was applied every four days rather than the prescribed every three days. The register showed that an interval of four days had lapsed before the old patch was removed and the new patch was applied rather than the prescribed time period of three days. This would mean that people may have experience unnecessary pain during this period.

We looked at records for people who were having the analgesic skin patches applied to their bodies. We found there were good records of where the patches were being applied however records showed that the patches were not always being applied in line with the manufacturers' guidance. For example, one person's pain relief patches were being rotated between the right and left shoulder. Manufacturers' guidance is for the same area not to be used for three to four weeks. Another persons' pain relief patches were being applied every four days and were being alternated between the left and right shoulder. Manufactures guidance states wait at least a week before using the site again. This meant the patches were not being applied safely and could result in people experiencing unnecessary side effects such as nausea, headache, application site itch, dizziness, constipation, sleepiness, vomiting, application site redness, dry mouth and application site rash.

When people had their medicines administered "when required" we found written information was in place to provide guidance to staff on how these medicines should be effectively administered. We however were

concerned with the administration of a sedative medicine for one person. The "when required" medicine was being administered on a regular basis but there was little written evidence that the person required it. This meant medicine may have been administered unnecessarily.

The registered provider was not able to demonstrate what advice they had taken from a pharmacist on how covert medicines [by disguising them in food or drink] could be safely prepared and administered. We also found that there was no written information to tell staff how to carry out this process safely and consistently. We spoke with a member of the day staff and they told us that the medicines they administered were administered with food. One of the medicines given by night staff needed to be administered at least 30 minutes before food but the day staff were unable to confirm this was happening. With no written information about how to administer medicines covertly we could not be sure that all staff members were administering medicines safely.

We found the administration records were good and were able to demonstrate people were getting their medicines at the times they needed them. We observed a member of staff supporting people to take their medicines. We saw it was done with care and followed safe administration procedures.

The registered provider had failed to ensure people were protected from the risks associated with their conditions and were not ensuring the safe care and treatment of people through appropriate management of medicines. This constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

People we spoke with told us they felt safe at the home. One person told us, "I feel safe because no-one can get in or out of the building who is not wanted." A relative told us, "I feel that mum is safe and secure." However, eight people we spoke with told us they thought there were not enough staff. One person said, "Sometimes there is not enough staff, sometimes at night there is no-one about." Another person said, "They need more staff, they are always rushing about, they might be in the middle of doing something for you and leave to come back later." A third person said, "There is not enough staff, sometimes residents wander into my bedroom if I leave the door open." 'Three of the relatives we spoke with told us they did not feel there were enough staff to support people. One relative we spoke with told us, "There is never enough staff." Eight members of staff we spoke with told us they did not feel there were adequate numbers of staff to support people which meant sometimes people's health and care needs were not met. One member of staff told us, "There is not enough staff; we are rushed off our feet." Another member of staff said, "[I] feel we need more staff, [we] don't always get our break."

Our observations found that units were often left with little or no staff which meant that people did not get timely care and support. One person who had pressed their call buzzer in their bedroom asked an inspector to help them attract the attention of staff. We found one member of staff in the dining area who said they were unable to leave the communal area unattended. The person's call buzzer was audible from the dining area but no staff had responded. The buzzer rang for approximately twenty minutes. We were advised that the person requires the support of two staff, therefore had to wait for two staff to become available on the other units. This meant that the persons' care and treatment needs had not been met as they had an unnecessary wait for support.

The registered provider advised us of how the staffing levels were determined. A staffing dependency tool had been used to determine the number of staff required at the service. They explained this was based on the broad provision of care the location is registered to provide. However, whilst the staffing levels had been assessed, records showed that there was not always enough staff on duty to ensure they could respond promptly to people's needs. On each of our inspection visits there were three staff members at work on

each unit. We observed when senior staff were administering medicines a care assistant remained in the communal areas which left one member of staff to meet the needs of people in their bedrooms and other areas in the unit. This meant people who required the support of two staff had to wait for staff from other units to support them with their individual needs.

The registered provider had failed to ensure there were sufficient numbers of staff deployed to meet people's care and treatment needs. This constituted a breach of Regulation 18 of the Health and Social Care Act 2009 (Regulated Activities) Regulations 2014. Staffing.

We looked at the registered providers recruitment procedures. Staff told us they had the required checks necessary before they were able to start working at the home. We checked four staff recruitment files and found pre-employment checks had been carried out. These included references, identification checks and Disclosure and Barring Service (DBS) checks. The DBS helps providers to ensure that potential staff members were of good character and suitable to work with people who live at the home.

People were protected from the risk of infection as there were adequate cleaning and infection prevention arrangements in place at the home. We saw the home was clean and the décor was well maintained. We observed care staff wore personal protective clothing when they supported people with their care.

The registered provider had systems and processes in place to check the environment was safe for people. We spoke with the cook who advised that they had daily and weekly cleaning schedules in place. The service had achieved a '5' star rating by the environmental health agency which meant they regarded the service as having good food hygiene standards. The registered provider had engaged external professionals to undertake regular check and services for the necessary supplies, such as gas, electric and water to make sure they were safe. We saw regular servicing of equipment such as the hoists and lifts had been undertaken. The registered provider employed a handyperson to undertake repairs when required to ensure the environment was safe to live and work in.

Staff were aware of their responsibility to report and record any accidents or falls. There were systems in place review these records to identify if there were any changes in people's needs and to look at ways of reducing the risks of it occurring again.

We reviewed records for health and safety checks, including fire safety and they were all in order. The registered provider had acted in accordance with the associated guidance for fire safety risk assessments in residential care premises .Each person had an individual emergency evacuation plan (PEEP), this documented the support they would require in order to evacuate the building safely in the event of a fire. Staff told us they attended regular fore drills and described their understanding of the actions they should take in the event of an emergency.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in November 2016 we rated this key question as, 'Good'. However we found the registered provider had not maintained this standard.

People told us that staff had the skills and knowledge required to meet their needs. One person told us, "There are very good carers they know how to look after you." A relative said, "They [staff] are skilled."

Most staff told us they had the skills or knowledge required to support people safely and promote their wellbeing. Training for staff was provided on a regular basis; however, although the training was offered we observed a number of examples where staff had not embedded their learning into practice. Staff had received safeguarding training but still failed to recognise abuse and had failed to consistently escalate and follow processes. This meant people had experienced harm. We found that staff did not always have the skills or time to work effectively with people living with dementia. People we met were at differing stages of their dementia and there was no plan about how the service kept up to date with developments in this area to ensure the care provided was appropriate and reflected best practice. Staff had limited knowledge and understanding of how dementia affected people in their day to day living. One member of staff told us, "[I] would like more dementia training around coping and defusing techniques."

When staff began working at the home they completed an induction. One staff told us, "I'm quite new and the induction has been good. I've been able to shadow other staff." The registered provider had ensured their induction processes were in-line with the principles of the Care Certificate. The Care Certificate is a nationally agreed set of fifteen standards that health and social care workers follow in their daily working life. It was launched in April 2015 and providers regulated by the CQC are expected to ensure that the standards of the Care Certificate are covered in their induction of new staff.

Staff we spoke with told us that they felt supported in their roles and that the management team were approachable. Staff told us that the home manager checked their practice through regular supervision and observation of their practice. This enables staff to reflect on and improve their practices.

The registered provider informed us that they conducted an initial assessment of needs before people moved into the home, to ensure they could be supported effectively. However, they also informed us that they were unable to meet some people's needs who lived at the home. Whilst they had started to address this, this did demonstrate that the initial assessment process was not robust. This put people at risk of not receiving care and support which met their needs or reflected good practice and industry standards.

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.

We checked whether the service was working within the principles of the MCA. One person we spoke with told us that they had a key to their bedroom and said, "Staff do ask my permission if they can go into my room." Another person told us, "They [staff] always ask my permission, and they are so respectful." Staff were able to describe the basic principles of the MCA and understood the importance of obtaining consent. Staff we spoke with told us that people were asked for their consent before they provided any care or support. A member of staff told us about a person who lacks capacity and said, "I show them different clothes and ask if they want to get dressed, sometimes they shake their head to say 'yes' or 'no'." During our inspection we observed staff gaining consent from people before supporting them with their needs. For example, asking people where they would like to eat their meals and if they had finished their meals before removing plates.

Records showed that people's capacity to make decisions about the care and support they received had been assessed when appropriate in relation to decisions around the use of equipment such as sensor mats. However, we found where people had to have their medicines administered covertly [by disguising them in food or drink] the provider did not have all of the necessary measures in place to respect people's rights. For example, we found no evidence that a decision to administer medicines covertly had been made by a multi-disciplinary team to confirm it would be in the person's best interest.

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. The application procedures for this in care homes are 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 were being met. The registered provider made us aware that a number of applications for DoLS had been made inappropriately or had not been made when required. The registered provider acknowledged that further work was needed in this area and were working to address this. The staff we spoke with did not always know which people were subject to authorised DoLS. This meant people were not protected by those conditions in place because staff were not aware of the people whose liberty was being restricted. Care records we reviewed lacked detail about people's authorisation and or if any conditions were attached to them. The registered provider had not worked with the staff team to make sure they understood who was legally authorised under DoLS and how best to support them with their restriction, ensuring least restrictive practices were followed. This meant people were at risk of staff applying restrictions to people's care and treatment which they were not legally entitled to do.

People identified as being at risk of malnutrition were not always supported appropriately. We found that food and fluid monitoring charts had not always been completed fully. For example, the daily totals of the fluid consumed by one person were not evaluated or consistently recorded. This meant staff were not aware if the person had consumed enough to maintain good health and remain hydrated. On one-day the person's fluid chart recovered they only consumed about half the amount of fluid they required to stay hydrated. There was no evidence that the person had been offered additional support to reduce the risk of dehydration.

People had a choice of meals and where to eat. People told us that in general they like the food that was offered. One person told us, "The food is satisfactory; we have plenty to eat and drink. We are never hungry." Another person said, "Food is lovely, plenty of choice." A relative we spoke with said, "We can go get drinks for ourselves or dad whilst we are here." There was a set menu in place but people told us they could have an alternative choice if they preferred. We observed drinks and snacks were offered between meals. Dining room tables were laid with tablecloths, napkins and cutlery and people were able to sit with friends. We saw support was provided by staff when necessary and staff sat and ate meals together with people. This promoted a positive mealtime experience for people.

People were supported to see healthcare professionals such as their GP, dentist and optician to maintain their health. One person told us, "I can see a GP, chiropodist, optician [and my] family would take me to the dentist." A relative said, "They [staff] would tell us if there was any change in our relative's health and if a doctor is needed." The home manager told us they had good working relationships with the community nurses, doctors and mental health teams.

The premises had been adapted and decorated to support people to move easily from their own bedroom and around the communal areas of the home. There were several communal rooms where people could sit and read rest or watch what was going on around them. We saw people who were able to mobilise independently moved freely between the communal areas and their own bedrooms. The shared toilets, bathroom and shower room were adapted with level seats, a shower chair and a bath chair to enable people to be as independent as possible or to be supported when needed. There was a garden which people could use independently or with support from staff.

Requires Improvement

Is the service caring?

Our findings

At our last inspection in November 2016 we rated this key question as, 'Good'. However we found the registered provider had not maintained this standard.

We observed that staff were kind, compassionate and treated people well. Although staff were caring in their interactions they had not recognised the need to protect people from potentially abusive situations and did not appear to recognise the severity of the situation. Due to some of the wider failings people living at the home did not always benefit from a caring culture.

Although staff spoke positively about their work and the people they cared for they did not have the time to build relationships with people. We saw numerous occasions where people were sat in the lounge areas of the home without any interaction from staff. When staff did interact we saw they were kind and friendly however, interactions were generally tasked orientated. For example, when people required direct support with personal care, to move or when eating and drinking and this meant there was little time available for one to one interactions with people or respond to their needs in a timely manner. We saw groups of people sitting in the dining room with staff, and whilst there was some engagement staff were completing paperwork at the same time. We saw examples of staff telling people that were asking for care and support they would' "be back in a minute", however people continued to have to wait. This meant staff did not have enough time to engage with people and promote their social interaction.

People we spoke with told us, they were mostly happy with the care they received. One person told us, "Staff are kind and we have a laugh together." One relative told us, ""The staff are friendly and caring." However, we did received some less positive comments which included, "Some staff are excellent, and some are not so good." and "They [the staff] could be a bit better looking after us, sometimes you can see two or three staff talking amongst themselves and people need attention."

People's privacy and dignity was not consistently respected and promoted. From a communal corridor we observed one person lying on their bed in a state of undress. The door to the persons' room had been left open. Another person was observed walking around the corridor in soiled night clothes due to their unmet continence needs. People had mixed views about how staff respected their dignity and privacy. One person told us, "The staff knock before entering my room." However, one person told us, "The staff respect my privacy to a point." Another person said, "They are always losing my clothes and giving me others with other resident's name on it." Although staff we spoke with were aware of how to promote people's dignity, this had not been consistently practiced.

People were given choices and supported to be involved in their care. One person told us, "I go to bed when I want to. Last night I went at midnight and listened to my music." Another person told us, "I do choose sometimes to have my meals in my room". People were encouraged to personalise their bedrooms as they wished. Bedrooms displayed items such as keepsakes, pictures, photographs, plants and ornaments. People shared with us examples of how they were supported and encouraged to maintain their independence where possible. One person told us, "They [the staff] support me to be independent. I do my

own personal care." Staff we spoke with understood the importance of how to promote and support people's independence. Whilst we observed staff promoting people's independence with tasks such as allowing people to walk with their walking frame and promoting people's independence at meal times; we did not observe many opportunities for some people to take part in everyday living skills, for example, helping to set a table for lunch if they wanted.

One person who lived at the home told us, "I do have people to speak on my behalf if needed". At the time of our inspection there was no-one living at the home who required advocacy support. Advocates are trained to support and enable people to make decisions.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in November 2016 we rated this key question as, 'Good'. However we found the registered provider had not maintained this standard.

People did not consistently receive personalised care from staff as they were not always aware of or responsive to people's individual care, emotional and support needs. One relative we spoke with told us, "I don't feel it's special for mum, [it's] the same for everyone." We saw staff failing to respect a person's wish to be called by their preferred name even though this was recorded in their care plan. We also noted that the persons' preferred name was not the one displayed on the person's bedroom door.

The registered provider did not consistently ensure that staff had the time to support people to engage in their known social, religious and cultural needs. Although one relative told us that they supported their relative to religious services, we found not all people were supported to follow their interests and take part in activities that reflected their social and cultural preferences. For example, one relative we spoke with told us their loved one used to be very involved in religious practice but had not been supported to worship since using the service. There was no evidence that staff had engaged with the person about their religious needs.

We received mixed feedback from people regarding the suitability of activities at the home to meet peoples' preferences. One person said, "There's nothing going on, I get so bored." A relative told us, "I visit and they [people] are all sitting in front of the television. My mum likes reading and doing puzzles." There were no dedicated activities staff employed and care staff told us they did not always have time to organise activities themselves. We discussed this with the registered provider who informed us that that an activity co-ordinator had been appointed and was completing their induction. During our inspection visit we saw staff support some people to engage in activities such as manicures, pancake day and an exercise class which people enjoyed. However, on the second day of our inspection we observed limited activities offered to people and on the final day of our inspection we saw no activities being offered. There were no activities in place to support people who lived in their rooms to pursue activities they enjoyed or help to prevent social isolation. One member of staff told us that it was hard to meet the social needs of people who chose to stay in their room and said, "[there's] not enough staff."

Staff did not engage people in meaningful activity. For example, one person's care plan identified that the person enjoyed playing a specific musical instrument. The person told us, "I can play the keyboard and piano and would play it if one was here." The person had not been made aware of a music therapy room at the service and a keyboard and piano they could use. They had not been supported to continue their interest in music.

On day three of our inspection we observed one person who lived with dementia crying and in a great deal of distress. We intervened and offered reassurance and comfort. We reviewed the person's care plan and could not see that this anxiety had been explored and there was no guidance for staff in how to support the person when they became distressed. We did not see evidence that the registered provider had done all that

was reasonably practicable to engage with this person at this time of the day and minimise their distress.

As part of our inspection we reviewed the website for Bartley Green Lodge. The website stated that the home, "Provide dementia care and support people who live with dementia to live life to the full". We saw there was a range of tactile objects such as dolls and clothing around the home to support people who lived with dementia. However we saw very few people engage with these objects. We observed that most of the people who were living with dementia were not engaged in any meaningful activities and were left for long periods of time without any engagement or stimulation. Care plans for people living with dementia did not contain information for staff about how they were to support these people to carry out daily tasks. They did not inform staff how to promote people's independence, and how people's symptoms might fluctuate day to day. Without this information staff would be unable to act responsively to people's individual needs or know how they make a positive impact on the lives of the people who lived with dementia.

Each of the care plans we reviewed contained some degree of information about people's personal preferences, life histories and medical needs. However we found some need further improvements to ensure staff were fully aware of people's emotional and social needs. For example, one person told us of their interest in a particular sport, however there was no evidence that anyone had used this opportunity to engage with the person about their interest.

Care and support was provided as and when staff were available to do so but due to low staffing levels, people were often left for long periods with little or nothing to occupy them. Staff who had worked at the service for some time understood people's needs however they told us they lacked the time to support people engage in their interests or keep them company.

We observed people had little interaction and stimulation throughout the day and found no evidence to assure us people's social and emotional needs were met. The registered provider had failed to ensure people had access to meaningful occupation which would support their wellbeing and meet their individual needs and preferences. This constituted a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care.

People's needs had been considered in relation to the Equalities Act and there had been some consideration of this in people's care planning. The registered provider told us no-one living at the home had any specific support needs relating to any protected characteristics. However, the registered provider had not explored ways to make sure people had access to the information they needed in a way they could understand it and comply with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The registered provider had not offered people the opportunity to receive information in alternative formats such as an alternative language, large print or pictorial format. The registered provider advised us that this would be addressed following our inspection.

People we spoke with knew how to raise a concern or make a complaint and staff knew how to guide people if they wished to formally complain or raise any issues. People told us they had no complaints, but said they would be comfortable to make a complaint if they wanted to. One person told us, "If I have any concerns, I would speak to one of the original staff." One relative told us, "Any complaints [and] I would go straight to the manager." The registered provider had a formal procedure for receiving and handling concerns. A copy of the complaints procedure was clearly displayed in the home.

The manager told us that people's end of life wishes were recorded in their care plans if people wished to

discuss it and through informal conversations. People's end of life care needs and future decisions were documented and contained within care plans to help ensure people's wishes and choices were respected.

Inadequate

Is the service well-led?

Our findings

At our last inspection in November 2016 we rated this key question as, 'Good'. However we found the registered provider had not maintained this standard.

Improvements were required to protect people from harm. Systems did not ensure staff understood people's risks and how to manage them. The registered provider had failed to ensure staff could recognise potential safeguarding concerns and how they would be responded to appropriately. Systems had not identified how people could be protected from the known risks associated with a person's specific condition and despite intervention from partner agencies, the governance systems had not been sufficient to ensure the situation was mitigated. The registered provider and management team had not ensured control measures were quickly and robustly implemented by staff and as a result people were exposed to on-going harm and abuse.

The registered provider failed to take prompt and effective action to address concerns. Following the second day of inspection we outlined our continued concerns with the registered provider. We returned back to the home for an additional day to ascertain if these immediate risks had been mitigated. We found evidence that the risks to peoples' safety had increased. Action had not been taken in response to mitigating all the risks we identified and we remained concerned about the capability of the registered provider to drive forward the improvements needed. We escalated our concerns to the Local Authority. Following our inspection we escalated the serious concerns we had identified to the registered provider. The provider is in the process of addressing the issues we identified.

People's health and well-being was not sufficiently protected as the registered provider had failed to monitor systems that ensured people received the care and support they needed. Systems to protect people's health and ensure they had enough to drink were not effective. The provider had not ensured effective monitoring was undertaken to reduce the risk of people developing pressure sores.

Systems to ensure there would be enough staff on duty to promptly meet people's changing care needs were not effective. Improvements were required in analysing information about people's abilities, emotional needs and dependencies to ensure staffing levels were reviewed and revised in line with increases in people's needs. We saw that staff were constantly unable to respond promptly to people's request for assistance or promote social interaction. People we spoke with and staff told us that they did not feel there were enough staff to provide support. Quality assurance systems did not consider the impact of inadequate deployment of staff to enable person-centred care and a good quality of life. The registered provider had failed to ensure people had access to activities which would support their wellbeing and meet their individual needs and preferences.

Improvements were required in analysing information that was available to the registered provider to drive improvements. Whilst the provider had monitored accidents and falls we found some serious incidents which had not been reported and as a result the appropriate action had not been taken to mitigate risks and harm to people. This meant that some people had experienced repeated harm.

Improvements were required in the governance of the service. Systems in place to monitor the care and support people received were not effective or used consistently. Audits had not been effective at identifying poor practice with risk management, care records, management of medicines, staffing levels and applying the principles of the Mental Capacity Act. This resulted in us identifying multiple breaches of the Health and Social Care Act 2008 (Regulated Activities). These breaches placed people at risk of receiving care and support that was inappropriate, unsafe and did not meet their needs.

Systems had not been established or operated effectively to assess, monitor and mitigate the risks to people's health, safety and welfare. This constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance.

Improvements were required to ensure the registered provider met all of the requirements of their registration. The provider had appointed a home manager however they had not yet registered with the commission. Organisations registered with the Care Quality Commission (CQC) have a legal responsibility to notify us about certain events that have taken place. However during the inspection we became aware of incidents of potential abuse which had impact on the health and well-being of people. The service had failed to monitor the service to ensure timely and appropriate action had been taken to protect people from harm. The registered provider was required to tell us about these incidents, but had failed to do so.

Failure to notify us of incidents as required was a breach of Regulation 18 Care Quality Commission (Registration) 2009 Notification of other incidents.

We looked at how the registered provider gathered people's views and how they promoted a positive and open culture. A relative told us, "I like the new home manager, they are approachable." We saw that resident meetings had taken place with people in order to obtain their views about their experiences of living at the home. The registered provider conducted annual satisfaction surveys of people's views to identify areas of improvement to be made within the home. The results of the surveys had been analysed, however, it was not clear from records what actions, if any, the registered provider had taken as a result of the survey.

Staff told us they attended meetings which were used to share information and to give guidance and direction to staff as well as planning and discussing people's support and care. Through discussions with the home manager it was clear that their aim was to re-establish a culture that promoted openness, honesty and transparency. Staff confirmed that team meetings had been held where they were introduced to the home manager. Staff members spoke positively about the recent management changes. One member of staff told us, "[name of home manager] has been on the floors [communal areas] and comes and talks with us." The registered provider told us that they hold monthly kindness awards where staff are nominated by the people who live at the home. Staff also demonstrated an understanding and awareness of the provider's whistleblowing policy and felt confident they could raise any issues with the home manager and these would be addressed.

The service worked in partnership with other agencies to support care provision and development. The home manager told us how they shared appropriate information with other health professionals for the benefit of people who use the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider had failed to ensure people had access to meaningful occupation which would support their wellbeing and meet their individual needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had failed to ensure people were protected from the risks associated with their conditions and were not ensuring the safe care and treatment of people through appropriate management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure there was sufficient numbers of suitably skilled and experienced staff to meet people's care needs.

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 18 Registration Regulations 2009 Notifications of other incidents The registered provider failed to notify us of incidents as required.

The enforcement action we took:

We have used our enforcement powers against the registered provider for failure to comply with a condition of their registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered provider had failed to protect people from the risk of abuse and improper treatment and systems had not been established to prevent the risk of abuse.

The enforcement action we took:

We have taken urgent enforcement action to impose immediate conditions on the registered provider's registration in order to protect people's safety and well-being.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider did not have effective systems in place to assess and monitor risks relating to the health, safety and welfare of people using the service.

The enforcement action we took:

We have taken urgent enforcement action to impose immediate conditions on the registered provider's registration in order to protect people's safety and well-being.