

Charing Gardens Limited

Charing House

Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Requires Improvement ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

About the service

Charing House accommodates 88 people in one adapted building. Charing house accommodates people across five separate wings, each of which has separate adapted facilities. Two of the wings provide residential care and the remaining wings provide care including nursing care.

People's experience of using this service

People's experience of care varied. While some people spoke highly of their experience and their relationships with staff, others told us they received task-based support from staff who lacked compassion.

The risks faced by people during care were identified, however plans in place to mitigate risks lacked detail and records did not consistently show risk assessments were followed.

People were supported to take their medicines by trained staff. We saw staff did not always follow best practice guidance when supporting people to take their medicines.

People told us they did not feel there were enough staff. Records showed there were enough staff on duty, but we saw they did not work effectively to ensure people's needs were met.

People's views and preferences were not captured in their care plans or reflected in the records of care. People told us they received task focussed support. People told us they did not like the food and the menu lacked variety. We saw people had been raising the issues around the menu for a long time and did not feel anything had changed.

People gave us mixed feedback about the attitude of care staff and their experience of care. Some people told us they felt staff were kind and caring, but others told us they did not think staff had the right tone to support people in a care setting. Staff did not always demonstrate they understood how people's sexual and gender identity may affect their experience of care. We have made a recommendation about this. People were supported through the use of appropriate equipment to maintain their independence.

People did not always receive person-centred care as their preferences and choices were not captured. Care plans were reviewed regularly but staff did not take the opportunity to add details of people's preferences.

Some people living in the home were receiving end of life care. People were only asked for very basic information about their end of life wishes. We have made a recommendation about supporting people to plan for the last stages of their life.

People and staff gave us mixed feedback about the approachability and responsiveness of the registered manager. While some people found her approachable and responsive, others felt she was not. Despite a range of audits and quality assurance systems being in place, issues with the quality of the service had not

been addressed. The registered manager worked with the local authority and local health services to stay up to date with local practice and guidance. People and staff did not always feel engaged with the provider as meeting minutes showed issues they raised were not always resolved.

People were kept safe from avoidable harm and abuse by staff who knew how to identify and escalate concerns.

Most staff had completed the training they needed to perform their roles. Where they had not completed training the registered manager addressed this through supervisions and the disciplinary process.

Where people lacked capacity the provider had made appropriate applications to deprive them of their liberty. However, in other areas they had not applied the principles of the Mental Capacity Act (2005). People were not always supported to have maximum choice and control of their lives and the service did not consistently support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice.

There had been an increase in activities provision and people told us they liked going on trips to the community and when external community groups visited the home. People knew how to make complaints and we saw complaints were responded to in line with the provider's policy.

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 April 2017).

Why we inspected

This was a planned inspection based on the previous rating.

Enforcement

We have identified breaches in relation to appropriate risk assessments, personalisation of care and good governance.

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

Follow up

We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement ●

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement ●

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement ●

Charing 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

The inspection was carried out by one inspector, an assistant inspector, a directorate support coordinator, a nurse specialist advisor and an expert by experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type

Charing 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 the inspection

Before the inspection we reviewed information we already held about the service. This was in the form of notifications they had submitted to us. Notifications are reports about information or events that have happened that providers are required by law to tell us about. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We used all of this information to plan our inspection.

During the inspection

During the inspection we spoke with eight people who lived in the home and four relatives. We spoke with 13 members of staff including the registered manager, the deputy manager, the assistant chef, two nurses, two senior care workers and five care workers.

We reviewed the care files for nine people, including assessment details, care plans, records of care and medicines information. We reviewed seven staff files, including recruitment records, supervision and training records. We reviewed meeting minutes, various quality assurance checks and audits, and other documents and records relevant to the management of the home.

After the inspection

We continued to seek and received clarification from the provider to validate evidence found. We provided clarification to the provider's Director of Operations about the feedback given during the inspection. We received documents and records we had requested from the provider to validate evidence found during the inspection site visit.

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 now deteriorated to requires improvement.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

- People were not consistently kept safe from known risks as plans to mitigate risks were generic and lacked personalisation.
- Risk assessments described people's needs but did not provide staff with details on the actions they should take to mitigate the risks. Moving and handling risk assessment templates required staff to indicate people's physical needs and limitations. However, there was no detail about what this meant for an individual. For example, two people's moving and handling risk assessments identified they had "Upper / Lower limb weakness" but it was not clear if this was all four limbs, or what the extent and impact of this weakness was. This meant staff may not know how to support them safely as their risk assessments lacked detail.
- Other risk assessments contained within files had not been completed. For example, one person's bathing risk assessment stated the safest method of supporting the person with bathing should be identified but nothing was completed on the record. This record had been reviewed and noted as being in place despite not being completed.
- Records did not consistently demonstrate risk assessments had been followed. For example, one person was identified as being at risk of developing pressure wounds and was meant to be repositioned every three hours. On the day of the inspection they were not repositioned between 07:40 and when the records were checked at 15:20. Staff on duty confirmed this was not a recording error and the person had not been repositioned since the morning. While this person had not developed any wounds the plan to reduce this risk had not been followed which heightened the risk for them.
- Care files also contained generic risk assessments that did not apply to people. For example, all the care files reviewed contained a risk assessment in relation to the use of paraffin based products. None of the people whose files were reviewed were using paraffin based products and therefore were not at risk from their use.

The above issues are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- Staff were recruited in a safe way. Staff were not deployed effectively to meet people's needs.
- Records showed staff were recruited in a safe way which ensured they were suitable to work in a care setting. The provider carried out checks to ensure staff were suitable and interview processes were

consistent and fair to all applicants.

- The registered manager acknowledged there was a high level of use of agency staff, particularly nurses. They told us that the agency staff were used regularly and therefore knew people living in the home well. The registered manager told us they faced challenges recruiting nurses due to local workforce pressures but were pleased they had recently appointed both a clinical lead and a nurse.
- The provider used a recognised dependency tool to calculate staffing needs in the different wings of Charing House. Records showed the number of staff scheduled to be at work attended. Although some staff told us absences were not always covered, this was not supported by the records and therefore was exceptional rather than routine practice.
- However, people told us they did not feel there were enough staff available to meet their needs. People's feedback about the staffing levels included: "No, definitely not [enough staff]. They could do with a few more hands;" "No, it's not enough. The number of times you are promised [support] and they [staff] forget because they are so busy." And, "You have to wait a long time to get attention."
- We watched staff at work in several of the wings and saw staff did not work in a way that responded to people's individual needs and preferences. For example, at lunchtime on one wing five staff were focussed on serving meals and tidying up with only one member of staff interacting with people and supporting them to eat. After most people had finished eating all the staff left the dining area, some were taking breaks while others were supporting people in their bedrooms. This meant one person had to wait to return to their bedroom. The person told the inspector "I get told off if I go by myself." A staff member walked past the dining area while taking a dining trolley back to the kitchen, confirmed this by saying loudly "You're not allowed to go by yourself." It took a further ten minutes to locate a member of staff who supported this person to return to their room.
- After the inspection the provider sent us an action plan which included staff meetings and training to remind staff how they should work in a responsive way to ensure people did not feel they were having to wait for support.

Using medicines safely

- People were supported to take their medicines as prescribed. However, staff did not always follow best practice in how they administered medicines, and information about medicines did not reflect best practice guidance.
- We saw that a nurse administering medicines through a feeding tube inserted into the person's stomach did not wash their hands before administering their medicines. We also saw a senior care assistant administered a person's eye drops at the dining table, interrupting their meal and conversation with other people to do so. These issues were discussed with the registered manager and the provider sent us an action plan which showed they had addressed this feedback with the staff concerned and introduced further checks to reduce the risk of recurrence.
- Medicines were stored securely and appropriately. Staff checked the conditions of the medicines storage daily, although we did note some gaps in the room temperature records, the registered manager's audits had also identified this and there were plans in place to address this.
- The provider used printed medicine administration records (MARs) printed by their pharmacist. The MAR contained the prescribers instructions but did not include details of the purpose of the medicine or any risks or side effects staff needed to be aware of. Care plans did not contain information about how to support each person to take their medicines in a personalised way. The provider sent us an action plan after the inspection which included reviewing and updating medicines care plans to ensure they reflected best practice guidance.

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

- People were protected from abuse and avoidable harm by staff who knew how to identify and respond to

allegations of abuse and harm.

- People and relatives told us they felt safe with staff, and they felt confident staff would take action to keep them safe. One relative said, "On the odd occasion I have been concerned about [my relative] the attention [from staff] has been prompt."
- Staff knew how to report and escalate concerns about people's welfare. Records showed incidents and allegations were recorded within the home and reported on to the appropriate local safeguarding authority. Records showed staff from Charing House cooperated with and facilitated investigations into allegations of abuse.
- Records showed incidents were discussed in staff meetings and care plans were updated to ensure people were safe after incidents took place.

Preventing and controlling infection

- Charing house was clean and free from malodour. While a small area of the home had some malodour in the morning, this dispersed during the day.
- Domestic staff were seen adhering to good practice in terms of infection prevention and control. We saw personal protective equipment was available for staff to use.

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 now deteriorated to requires improvement.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- Staff completed needs assessments based on recognised clinical tools. However, the resulting care plans lacked personalisation and detail.
- The provider's assessments identified needs in relation to people's physical health and wellbeing, including support needed to mobilise, maintain personal hygiene, eat and drink, maintain their skin condition and any help they needed with their health conditions. People were asked about their religious belief, cultural background and sexual and gender identity. The assessments had recently been updated to include the support people needed to maintain their oral hygiene.
- Care plans lacked detail about how to provide care in line with people's preferences. For example, one person required staff to support them with all aspects of their personal hygiene. In relation to how they wished to wash, dress or style themselves the plan simply stated, "Assistance x2 HCA with all care." Other care files contained a similar lack of detail, for example, one person's personal hygiene plan stated, "Daily shave, twice daily teeth clean. Encourage [person] to assist with this. Allow choice of clothing." There was no detail elsewhere in the file to explain this person's choices in relation to their care such as whether they shaved with an electric or manual razor. This meant there was a risk that people did not receive care in line with their needs and choices as these had not been captured during the assessment.

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

- People gave us mixed feedback about the food and mealtime experience.
- We observed lunch in three of the wings and found people were not consistently supported to have a pleasant mealtime experience. In two of the wings staff were not sure what the meal was they were serving people and had to check. In one wing people were very unhappy with the quality of the food and complained directly to the kitchen staff.
- People told us they did not feel the food was good quality, and that the variety on the menu was poor. For example, one person said, "It [the food] is variable. I think that is the kindest thing for it. I call roast potatoes armoured potatoes." Another person said, "I would give it a massive thumbs down." We saw people were unhappy with their pudding as it was too hard for them to break up with a spoon.
- Residents meetings showed people regularly complained about the variety of the menu and quality of the food. We spoke to the kitchen staff who told us there were four week rolling menus for summer and winter. They told us the menu had not been changed for many years. The registered manager and deputy manager told us this was not true, and the menu was amended each year.

- People told us, and meeting records showed they complained about there being too much mince on the menu, and not enough variety. The registered manager and deputy manager told us they had introduced curries, and they did not believe there was too much mince. We reviewed the four-week menu for the six months of winter and saw all the options for Mondays were mince based. On two of the weeks both the main choice and alternative were mince-based. Across all four weeks of the menu curry was not an option. This showed people's views had not been taken into account.

The above issues with the quality of the care plans, and menu options are a breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- Staff told us, and records confirmed they received the training and support they needed to perform their roles.
- Records showed staff received regular supervision where they were encouraged to reflect on their role and performance. One staff member said, "Supervision is used to assess where I'm going wrong, or if the manager needs to support me or needs to send me for more training. We talk about complaints or things I'm not happy about. It's useful for me."
- Records showed the manager took concerns about staff performance seriously and took steps to work with staff to improve their work. This included providing additional training and supervision until staff worked to the required standards.
- Staff told us they completed online training and found this helped them in their roles. New staff confirmed they completed an induction workbook which supported them to develop their knowledge.
- The training matrix showed staff completed training relevant to their roles. Where staff were due to repeat training this was highlighted, but it was not always clear that this resulted in staff completing the training. We saw some training, including medicines training and moving and handling training, had been overdue for completion for over a year. The registered manager told us staff were reminded to complete training at supervision meetings and failure to complete training led to disciplinary processes being followed.

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

- People were supported to access healthcare services, and staff worked with other agencies to ensure people received the right support.
- People told us staff supported them to attend appointments and supported them with following medical professionals' advice. One person said, "If I felt unwell I would call one of the nurses. I have a few times and they kept me in bed. They would call the doctor, but only if it was necessary." A relative told us about the different agencies involved in their family member's care and how the service helped to coordinate this for them.
- Care files contained information about the advice of healthcare professionals to ensure this was shared with staff. For example, where people had difficulties swallowing the recommendations of speech and language therapists were within the files. We saw specialist advice from nutritionists, dentists and specialist nurses had been incorporated into care files.
- Staff made records of visits by healthcare professionals. Staff told us they arranged transport and informed relatives of appointments outside the home.

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

- The building was arranged into separate wings. Each part of the home was secure and separate from the others. Within each wing, there was information to help people identify different rooms.
- The home had undertaken some refurbishment work and an active programme of repair was ongoing.

There were plans to improve the courtyard areas to make them into accessible gardens. The home had already transformed one room to look like a pub. The registered manager told us people could have non-alcoholic drinks and used the area to play cards. When asked if people could have an alcoholic drink if they wished, the registered manager confirmed they could.

- People were able to personalise their bedrooms if they wished to do so. We saw some bedrooms were highly personalised with bespoke decorations.
- Walkways and hallways across the home were broad and had enough room for people who mobilised with aids or used wheelchairs to move around freely.

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.

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's capacity to consent to their care and treatment was assessed. It was not always clear the service was following best practice in relation to the MCA.
- Where people were assessed as lacking capacity to consent to their care and treatment, the registered manager had made appropriate applications for DoLS.
- Where people were assessed as having capacity the service did not consistently follow best practice. For example, people's relatives were asked their opinion on matters relating to their care, when they were able to make these decisions themselves, and communicate their views clearly. There was no indication people had requested others to make those decisions on their behalf.
- We also noted the environment was restrictive. Each of the wings was locked with a keypad code for both entry and exit. Although there were risk assessments and consent forms for people who had capacity and were not subject to DoLS, the locked environment was by its nature restrictive and it was not clear less restrictive options had been considered. People relied on staff to facilitate them leaving the wings.

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 now deteriorated to requires improvement.

This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- People's experience of care varied. While some people told us they were treated kindly, others did not always feel this way.
- Care files contained information about people's culture and background. However, staff did not always demonstrate they understood how people's cultural or sexual identity could affect their experience of care. For example, one member of staff said, "On admission we make sure they update care plans to reflect change in sexuality." Another staff member said, "By observing how they dress, move and their appearance. When you know that they are LGBT [Lesbian, Gay, Bisexual or Transgender] you don't joke about it" This does not demonstrate a good understanding of the impact of sexual and gender identity on people's experience of care.

We recommend the service seeks and follows best practice guidance from a reputable source about ensuring staff understand the impact people's sexual and gender identity can have on their experience of care.

- Some people told us they thought the care staff were, "fantastic," "Lovely" and "Can't do enough for me." However, other people told us their experience was not always positive. One person explained, "Tone is very important to me, and the way they [staff] interact with me. There is about 60% who don't have the right tone." Another person spoke about having their needs met without tolerance from staff.
- Staff told us faith representatives visited the home regularly and people attended religious services if they wished to do so.

Supporting people to express their views and be involved in making decisions about their care

- People's views about their individual care and treatment were not well captured, though people were confident to speak their minds.
- Care plans lacked information about people's views about their care. Although people had signed to indicate they were involved with their assessments, it was not clear that people had taken an active role in saying what their needs were as their views were not reflected in the documentation.
- However, we observed people were clear in communicating their views with staff throughout the inspection. People and relatives told us they could contribute their views and took the opportunity to do so. One person said, "Yes I do [express my views] which I do if I feel it is necessary."

Respecting and promoting people's privacy, dignity and independence

- People were supported to maintain their independence and most staff treated them with dignity and respect.
- People told us, and records confirmed that they continued to do things independently. Care files included details of the things people could do for themselves and should be encouraged to continue to do independently.
- We saw people were supported to use equipment to maintain their independence with eating and drinking.
- Staff described how they supported people to maintain their dignity. Some staff spoke very compassionately about how they would respond if someone was embarrassed or upset by a care need. One care worker said, "I hold their hand and talk patiently to them. I tell them it's fine and there is no need to feel embarrassed."
- However, other staff did not demonstrate a compassionate attitude to people's experience of their dignity being compromised. One staff member said they would explain an unexpected care need in terms of the medical symptoms rather than offering reassurances.

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 now deteriorated to requires improvement.

This meant people's needs were not always met.

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

- Care was planned in a way that ensured staff knew what people's needs were, however there was limited information about people's preferences.
- Care plans were task focussed and described people's needs. In the section of the care plan where staff were meant to record how to meet the need, staff had frequently just repeated what the person's needs were.
- We also found some discrepancies between information people told us and the information in their care files. For example, one person's care file said they did not practice their faith, but they told us how they regularly went out with faith representatives.
- People's feedback about their experience of care stated they found the approach of care staff task focussed, reflecting the lack of detail in the care plans. One person explained, "They provide for me, but that's a bit different from caring."
- Records showed staff reviewed people's care plans each month. We noted that staff did not take the opportunity of the review to add further detail and personalisation to the care plan. Most reviews simply stated that the plan remained in place and did not show people had been asked their views on care.
- The provider has sent us an action plan where they included refreshing their training for staff and increasing the levels of personalisation in the care plans.

End of life care and support

- Some people living at Charing House were receiving end of life care and support.
- When people moved to Charing House specifically to receive end of life care, they were supported by trained nursing staff who worked to ensure they were supported to be pain free and comfortable. The provider told us they created a basic care plan based on specified assessments when people moved in for end of life care and only created a full care plan after three months. We saw this basic care plan lacked personalised detail and focussed on physical needs rather than taking a holistic approach to the person.
- People had not been supported to explore their wishes should they reach the last stages of their lives. Care files contained a basic form which was addressed to, and completed by, people's relatives asking about whether people would want to stay at Charing house, emergency contacts and funeral arrangements. This had been completed by relatives even when the person concerned had full capacity to make these decisions. People had not been supported to consider and record cultural, spiritual or social wishes in relation to the last stages of their life.

The above issues with personalisation and end of life care are a breach of Regulation 9(3) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

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 told us they had information about the service in formats they could access.
- We saw an accessible version of the complaints procedure had been shared with everyone who lived in the home.
- Where people wished, the registered manager would meet with them and explain policies or developments in person rather than relying on written communications.

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

- People were supported to attend activities in the community, and relatives told us they felt welcome to visit Charing House whenever they wished.
- Charing House employed two activities coordinators. People told us there had been improvements in the activities. However on the day of the inspection the activities coordinators were absent and no activities were facilitated.
- We saw photographs of people going out on day trips in the local community and of visiting groups including musicians and a local baby group. People confirmed the activities coordinators supported them out on trips. One person said, "I have been out for a few trips, shopping and lovely coffee mornings. There are no activities today."
- People who were unable to leave their bedrooms told us their activities were limited. One person said, "I do very little as I can't get around." Although staff told us people were supported with one-to-one activities this was not captured in their notes, and we did not see this taking place during the inspection.

Improving care quality in response to complaints or concerns

- People told us they knew how to complain, and their complaints were responded to appropriately.
- People were given copies of information about how to make complaints and we saw this was on display in people's bedrooms. One person told us, "The staff are all telling me how to complain." We saw care workers encouraged people to raise complaints during the inspection.
- Records showed complaints were investigated and responded to in line with the provider's policy.

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 now deteriorated to requires improvement.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider had a schedule of checks and audits which were completed to monitor the quality of the service. However, these had not identified or addressed the issues identified during the inspection.
- The registered manager had introduced supplementary audits of records in response to issues identified with the completion of people's records of care. However, we identified issues with the completeness of records remained during the inspection.
- The systems in place had failed to identify or address the issues with the application of the MCA or understanding of the impact of sexual and gender identity on people's experience of care.
- Audit records and conversation with the registered manager showed they had identified issues with the lack of personalisation within the service. The registered manager said to us, "The staffing situation means that we've lost the person-centred knowledge." The registered manager told us the difficulties in recruiting permanent nursing staff who could lead in writing and reviewing person centre care plans was the root cause of the deterioration in the quality of the service.
- The registered manager and deputy manager told us that they were completing audits and checks themselves that they would prefer to be able to delegate to staff who managed the wings. Although staff had been recruited they had not started at the point of inspection.
- Despite the range of audits and quality checks in place, there was no central action plan in place to pull together the work needed to improve the quality of people's experience of care. In response to the feedback during the inspection the provider submitted an action plan.

The above issues together with the failure to identify and address issues with the quality of the service are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Although the manager tried to promote a positive, person centred culture, much of people's experience was of task focussed support.
- Meeting records showed the registered manager articulated a positive vision for the service, based on personalisation and engagement. However, this was not reflected in people's experience of care and staff practice. People told us they found staff did not have time to provide the additional touches that would lead

to a person-centred approach. One person summed up their experience at Charing House by saying, "I can't say I enjoy it. It is somewhere where I am no longer a burden."

- Staff meetings were held regularly. These showed staff spoke openly in these meetings, and raised issues frankly where they perceived colleagues were not working in a collaborative way. Records also showed staff meetings were used to cascade information and training to staff including on sexuality, personalisation and medicines practice.
- People and staff gave us mixed feedback about the approachability of the registered manager. Some people and staff told us they found her welcoming and supportive. One person said, "[Registered manager] is always walking about. There is an open door policy." However, other people and staff did not find the registered manager approachable.

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

- Records showed the provider understood their responsibility to share information with people and their relatives if anything went wrong.
- The provider completed appropriate investigations and communicated in writing with people and their families. People and relatives confirmed the registered manager would meet with them if they raised any concerns.
- The provider submitted notifications to CQC as required. Notifications are information about events which take place in services which providers are required to tell us about by law.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- There were regular meetings and opportunities for people and staff to be involved with the development of the service. However, people and staff did not always feel they were listened to.
- There were regular meetings for people, however, records showed that topics that people wished to speak about had been taken off the agenda. For example, one meeting showed that the food and menu had been taken off the agenda as it had dominated previous meetings. It was clear that this issue remained important to people at the time of the inspection and had not been resolved.
- Some people, and their family members, told us they felt able to speak directly to the management team and felt engaged.
- The activities staff were working to increase people's involvement with the local community, and to encourage groups from the local community to be involved with the home. Meeting records showed staff had invited local history experts and the Women's Institute to the home.

Working in partnership with others; Continuous learning and improving care

- The registered manager told us they worked closely with the local health services and local authority. They told us the local networks helped them stay up to date and ensured they had good effective working relationships.
- We saw that when a sister care home had been inspected the learning from that inspection had been shared through supervisions and team meetings in Charing House.
- However, Charing House had not stayed up to date with all best practice guidance. For example, their medicines practice and application of the MCA was not in line with current practice. The provider submitted an updated medicines care plan template to show they were responding to this feedback.

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
Treatment of disease, disorder or injury	People's preferences were not reflected in their care plans and people did not receive care in line with their preferences. Regulation 9(1)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Risks faced by people had not been appropriately mitigated as risk assessments lacked detail and were generic. Regulation 12(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Systems and processes had failed to improve the quality of the service. Regulation 17(1)(2)