Tonbridge Care Ltd

Chestnut Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We inspected the service on 3 April 2018. The inspection was unannounced. Chestnut Lodge Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission regulates both the premises and the care provided, and both were looked at during this inspection.

Chestnut Lodge Care Home is registered to provide accommodation and personal care for 60 older people and people who live with dementia. There were 41 people living in the service at the time of our inspection visit.

The service was run by a company who was the registered provider. There was 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. In this report when we speak about both the company and the registered manager we refer to them as being, 'the registered persons'.

At the last comprehensive inspection on 14 December 2015 the overall rating of the service was, 'Good'. However, after this we received concerning information that people were not always receiving safe care and treatment. We completed a focused inspection on 21 June 2017 to check that people were being kept safe. We found there were two breaches of regulations. This was because suitable arrangements had not been made to ensure that people consistently received safe care and treatment. Also, the registered persons had not suitably assessed, monitored and improved the quality and safety of the service given the shortfalls that had occurred in the provision of safe care and treatment.

We told the registered persons to take action to make improvements to address each of our concerns. However, the registered persons failed to submit written information to us saying what action they intended to take to enable the breaches of regulations to be met.

At the present inspection we found that sufficient steps had not been taken to address either of these breaches. This was because there were serious shortfalls in the arrangements used to provide people with safe care and treatment that had significantly increased the risk of people experiencing harm. There were also serious shortfalls in the systems and processes used by the registered persons to assess, monitor and improve the quality and safety of the service. This had resulted in the persistence of a large number of problems in the running of the service that had reduced people's ability to receive the high quality care to which they were entitled. In addition, the registered manager did not appreciate the seriousness of the concerns we had identified and there was no realistic prospect of them quickly being put right.

There were five additional breaches of the regulations. Robust recruitment checks had not been completed to ensure that that only people of good character were employed to work in the service. The

accommodation was not designed, adapted and decorated to meet people's needs and expectations. Care staff had not received all of the training and guidance they needed in order to know how to care for people in the right way. People had not always had their dignity respected and suitable provision had not been made to ensure that people always received person-centred care.

As a result of these breaches of regulations 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 registered persons' registration of the service, will be inspected again within six months. The expectation is that registered persons 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 registered persons 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. When 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 or overall, we will take action to prevent the registered persons from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

We also found that there were other shortfalls in the service. Sufficient care staff had not always been deployed. We have made a recommendation about the deployment of care staff. Suitable provision had not been made to ensure that people consistently received care in line with national guidelines. This included supporting people who lived with dementia if they became distressed. We have made a recommendation about ensuring that care staff have the knowledge and skills to provide enriched care for people who live with dementia. Complaints and concerns had not consistently been managed in the right way to reassure people that issues would be addressed. We have made a recommendation about the systems and processes used to respond to complaints and concerns. In addition, care staff had not identified as a cause for concern the numerous examples of poor practice we identified. This lack of insight had contributed to people not always receiving the safe and person-centred care to which they were entitled.

Our other findings were as follows: Medicines were managed safely and people were safeguarded from situations in which they may experience direct abuse. There were suitable arrangements to obtain consent so that people only received lawful care. People receive coordinated care when they moved between different services and they had been helped to obtain any healthcare they needed.

People had been supported to make decisions about their care as far as possible. This included them having access to lay advocates if necessary. Confidential written information was managed in the right way.

Arrangements had been made to promote equality and diversity. This included promoting the citizenship rights of people if they chose gay, lesbian, transgender and bisexual life-course identities. Provision had been made to support people at the end of their life to have a comfortable, dignified and pain-free death.

Care staff had been helped to understand their responsibilities to develop good team work. The registered persons were actively working in partnership with other agencies to support the development of joined-up care. The quality ratings we gave the service at our last inspection had been displayed and the registered persons had told us about significant incidents that had occurred in the service.

At this inspection seven breaches, including two continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified. Full information about CQC's regulatory response to the breaches of regulations relating to the breaches will be added to our report after any representations and appeals have been concluded.

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.

There were serious shortfalls in the arrangements that were intended to ensure that people received safe care and treatment.

Background checks had not been completed in the right way before new care staff were appointed.

Sufficient numbers of care staff had not always been deployed and organised in the right way.

Medicines were managed safely.

Suitable provision had been made to safeguard people from the risk of abuse.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Parts of the accommodation were not designed, adapted and decorated to meet people's needs and expectations.

Care staff had not received all of the training and guidance they needed to know how to care for people in the right way.

There were suitable arrangements to obtain consent to care and treatment in line with legislation.

Suitable provision had been made to enable people to receive coordinated care when they used different services.

People had been supported to receive on-going healthcare support.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Care staff had not been fully supported to provide care in a way

that always promoted people's privacy and dignity.

People were supported to express their views and be actively involved in making decisions about their care as far as possible.

Written confidential information was kept private.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People had not been offered sufficient opportunities to pursue their hobbies and interests and to take part in a range of social activities.

Although people received the practical assistance they needed, information about their care was not always presented to them in an accessible manner.

Systems and processes used to resolve complaints were not robust.

Suitable arrangements had been made to promote equality and diversity.

Suitable provision had been made to support people at the end of their life to have a comfortable, dignified and pain-free death.

Is the service well-led?

Inadequate

The service was not well led.

There were serious shortfalls in the systems and processes used by the registered persons to assess, monitor and improve the quality and safety of the service.

Care staff had not been fully supported to recognise situations in which they may need to speak out to ensure that people received safe and person-centred care.

There was a registered manager and care staff had been helped to understand their responsibilities to develop good team work.

The service worked in partnership with other agencies to promote the delivery of joined-up care.

Chestnut Lodge 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 registered persons were 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.

We used information the registered persons sent us in the Provider Information Return. This is information we require registered persons 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 also examined other information we held about the service. This included notifications of incidents that the registered persons had sent us since our last inspection. These are events that happened in the service that the registered persons are required to tell us about. We also invited feedback from a commissioning body who contributed to purchasing some of the care provided in the service. We did this so that they could tell us their views about how well the service was meeting people's needs and wishes.

We visited the service on 3 April 2018 and the inspection was unannounced. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is someone who has personal experience of using this type of service.

During the inspection visit we spoke with 14 people who lived in the service and with four relatives. We also spoke with five care staff, the administrator, one of the activities managers, a housekeeper and the maintenance manager. In addition, we met with the deputy manager and the registered manager. We observed care that was provided in communal areas and looked at the care records for eight people. We also looked at records that related to how the service was managed including staffing, training and quality assurance.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who were not able to speak with us.

After our inspection visit to the service we spoke by telephone with a further four relatives.

Inadequate

Is the service safe?

Our findings

At our last focused inspection 21 June 2017 we found that the registered persons had not established suitable arrangements to assess, manage and reduce risks to people's health and safety so that they consistently received safe care and treatment. This was because sufficient steps had not been taken after a fire had occurred in the service to rectify shortfalls in the fire safety system in line with the requirements of the local authority's fire and rescue service.

At the present inspection records showed that the fire and rescue service had confirmed that the necessary improvements had been completed. However, there were further shortfalls in the service's fire safety system. The registered persons had completed their own assessment of the adequacy of the service's fire safety equipment and had concluded that 21 further improvements needed to be made. The registered manager did not know which of the improvements had been made and furthermore there was no plan to progress any that remained to be completed. The registered persons had also not convened fire drills as frequently as they said was necessary. Furthermore, records showed that on two occasions in March 2018 prompt and effective action had not been taken to address defects in the fire safety system. This was the case even though the registered persons had been identified them as needing action. These shortfalls had seriously reduced the level of fire safety protection provided in the service and had increased the likelihood of people experiencing harm in the event of a fire.

Although after accidents had occurred steps had been taken to keep people safe, insufficient attention had been given to managing risks to people's health and safety before they had actually resulted in things going wrong. This included there being a number of unresolved trip hazards in the service. One of these was a steep step that changed the level of the floor between the conservatory and the dining room. Although there was a warning sign about the presence of the step we saw people having difficulty negotiating it. This was because the doorway was too narrow to enable people to safely climb the step while manoeuvring their walking sticks and walking frames.

There was another hazard in three of the communal toilets where the toilet seats were loose and easily slid off onto the floor as soon as any weight was put on them. A further issue was some poorly laid linoleum flooring in one bedroom that was badly rucked and which created a trip hazard. We also noted that the registered manager routinely brought her pet dog into the service. During our inspection visit we saw the dog running around in all areas of the ground floor without anyone controlling its movements. The animal darted between people's feet and on two occasions it collided with people who experienced reduced mobility and who were at risk of falling. These collisions resulted in the people concerned momentarily losing their balance until they were assisted to be more steady by the care staff who were accompanying them. All of these shortfalls had significantly increased the risk of people having avoidable falls and experiencing harm.

In addition to these oversights, suitable arrangements had not been made to ensure that people only went in to the walled garden via the patio doors when it was safe for them to do so. Although the patio doors were fitted with an alarm to let care staff know if someone wanted to go outside, when we tested it the device was

not switched on. As a result there was an increased risk that a person who lived with dementia might go into the garden on their own when in fact they needed assistance to do so safely.

The registered manager said that all windows located above the ground floor were fitted with safety latches that prevented the windows from opening too wide. This is necessary to ensure that windows can only be used safely when they are opened. However, the latches fitted to 17 windows did not comply with national guidelines because they did not sufficiently restrict how far the windows could be opened. This oversight had significantly increased the risk that a person would fall from a window that had been opened too far and sustain a serious injury.

The registered manager told us that it was important for all parts of the accommodation to be properly illuminated so that there was less risk of people tripping over. However, the light in one person's en-suite bathroom took more than five minutes to warm up and give out a reasonable level of light. In another bedroom none of the lights worked at all due to a fault that had developed several days before our inspection visit. A further problem was a defective light in one of the communal bathrooms which did not work at full power leaving the windowless room in heavy gloom.

The registered manager also said that it was important to control the temperature of hot water taps in areas of the service occupied by people who lived there. This was because people who lived with dementia may accidentally injure themselves if they came into contact with water that is too hot. We were told that the hot water service was checked regularly so that prompt action could be taken if the temperature was too high. However, a check completed on 28 March 2018 by the administrator had found that 18 taps were delivering water that was too hot. The registered manager did not know about this problem and no action had been taken to address the hazard that had significantly increased the risk of a person scalding themselves.

Records showed that the registered persons completed a regular audit that was designed to ensure that good standards of hygiene were maintained to prevent and control infection. However, these checks had not been effective in quickly resolving shortfalls. These included an area of carpet in the lounge that was dirty and heavily stained. Also, the handrails fitted in one of the showers were rusty and so could not be cleaned properly. This was also the case with 10 of the wall tiles fitted in the shower's enclosure. They were badly cracked and their damaged surface was discoloured with grime. All of these defects had increased the likelihood that people would acquire avoidable infections that would compromise their health.

Some people were not being supported to eat and drink enough to maintain a balanced diet. We were present when the lunchtime meal was served and we saw that three people did not receive the individual assistance they needed in order to enjoy their meal. This was partly caused by three care staff not being available to provide care at this busy time because they were completing administrative duties. We observed two occasions when people who lived with dementia finished their drink and then took the drink of another person who was seated at their dining table. Also, a person who did not want to have their main course was then given two puddings neither of which they were supported to consume. Another person was seen to eat very little of their meal and was left by care staff to sleep slumped over the dining table for nearly all of the meal time.

We examined the records relating to the additional arrangements that had been made to ensure that four people ate and drank enough to promote their good health. There were shortfalls in the provision that had been made for two of the people. One person needed to have their intake of food and drink monitored because a healthcare professional said that this was necessary due to their general health. However, no record was being kept of how much the person had drunk and the record of the food they had eaten was incomplete and of limited value. Also, the person had been prescribed a food supplement to help build up

their strength. Although care staff confirmed that the supplement was being provided its use had not been added to the person's care plan in the correct way. This had increased the risk that mistakes would be made and that the supplement would not consistently be offered to the person.

Records showed that a healthcare professional had said that another person needed to be offered snacks at all times because they were underweight. However, this advice had not been included in the persons' care plan and records did not confirm that care staff were complying with the advice that had been received. Although there was no evidence that the shortfalls had resulted in the two people experiencing direct harm they had increased the risk of this happening.

Records showed that risk assessments had been completed that were intended to ensure that people received safe care. These risk assessments included the additional care some people needed to safely get about, to promote their personal hygiene and to eat and drink enough. However, in practice the risk assessments had not been completed in a robust way. This was because they had not consistently identified and resolved the shortfalls we found that had reduced the registered persons' ability to deliver safe and harm-free care.

We raised our concerns about the management of risks to people's health and safety with the registered manager. They did not appreciate the seriousness of the shortfalls in question and were not able to give us a detailed account of the steps they would take to put things right. They were also not able to give us a clear timescale within which any changes would be completed. Therefore, we concluded that there was no realistic prospect of the shortfalls promptly being addressed as was necessary to ensure people's health and safety.

Failure to assess and reduce risks to the health and safety of people living in the service had seriously increased the risk that people would experience significant harm as a result of not receiving safe care and treatment. This was a continuing breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The registered persons did not operate robust recruitment and selection procedures. We examined records of the background checks that the registered persons had completed when appointing two new care staff and in both cases there were shortfalls in the checks that had been completed. In relation to one person the registered persons had not obtained a suitably detailed account of the applicant's employment history. This oversight had reduced their ability to determine from whom they needed to seek assurances about the applicants' previous good conduct. In addition, even though one person's records showed that they had previously worked in a care setting the registered persons had not established how well they had performed their duties during this period of employment.

Although other checks had been completed including obtaining clearances disclosures from the Disclosure and Barring Service, the shortfalls we found had increased the risk that people would not receive safe care. This was because there was a greater likelihood that applicants would be appointed to work in the service who were not suitable to have unsupervised contact with the people who lived in the service.

We raised our concerns about this matter with the registered manager. Although they said that the service's recruitment and selection procedure would be strengthened they were not able to give us a clear timescale within which the registered persons would complete the necessary improvements. Therefore, we could not be confident that the required changes would promptly be made to keep people safe.

Failure to operate robust recruitment procedures to ensure that people employed to work in the service

were of good character was a breach of Regulation 19 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us that they had carefully calculated the minimum number of care staff who needed to be on duty to enable people to safely and promptly receive all of the care they needed. However, they had not used a recognised management tool when completing their assessment. As a result we could not be confident that changes in people's needs for care would quickly be identified and reflected in the number of care staff deployed in the service. Also, records showed that over a period of 16 days in March 2018 nine care staff shifts had not been filled. We were told that the vacant shifts had occurred because care staff had been off work due to ill health and that it had not been possible to arrange cover at short notice. This situation had arisen because the registered persons had not established effective back-up systems such as having their own bank staff and/or agency arrangements by means of which to access additional staffing resources.

Although at the time of the inspection the service was fully staffed we found that care staff were not always being deployed in the right way. This was because there were occasions on which there were insufficient care staff available to provide people with the individual assistance they needed. In particular, there were shortfalls in the support people received to maintain their personal hygiene, to eat and drink and to enjoy taking part in social activities.

We recommend that the registered persons use a recognised tool to calculate how many care staff need to be on duty and how this resource should best deployed to ensure that people consistently receive person-centred care.

Medicines were safely managed in line with national guidance. There were suitable arrangements in place to safely order, administer and dispose of people's medicines. These included there being a sufficient supply of medicines that were stored securely. The care staff who administered medicines had received training. We saw them correctly following the registered persons' written guidance to make sure that people were given the right medicines at the right times.

People told us that they felt safe when in the company of staff. One of them said, "I'm pretty much okay there as the staff are kind to me even if they're a bit rushed on some days." Another person commented, "Staff are very attentive you can see that people who live here are what's important." A person who lived with dementia and who had special communication needs smiled and held hands with a nearby member of care staff when we used sign-assisted language to ask them about their experience of living in the service. Relatives also told us that they were confident that their family members were safe. One of them remarked, "I chose this place carefully as it has the right balance of being homely and professional. The staff are very good and I have no concerns about my mother's wellbeing."

People were safeguarded from situations in which they may experience abuse. Records showed that care staff had received training and knew how to recognise and report abuse so that they could take action if they were concerned that a person was at risk. They told us they were confident that people were treated with kindness and they had not seen anyone being placed at risk of harm. The registered persons had established suitable systems to assist the people to manage their personal spending money. This included keeping an accurate record of any money deposited with the service by relatives. This was done so that there was a clear account of how it had been spent on people's behalf to pay for things such as consultations with the hairdresser. This arrangement contributed to protecting people from the risk of financial mistreatment.

Requires Improvement

Is the service effective?

Our findings

Although most parts of the service had a fresh atmosphere the accommodation was still not designed, adapted and decorated to meet people's needs and expectations. Suitable steps had not been taken to support people who lived with dementia to find their way around their home. Although signs were fitted to bathroom and toilet doors these did not use easy-to-understand graphics that are often helpful for people who live with dementia. In addition, little had been done to distinguish most people's bedroom doors so that there was less risk of them entering the wrong room. We saw two people walking up and down hallways because they were not sure which bedroom they occupied. Each of them was anxious and this was not addressed until a member of care staff provided them with the assistance they needed to find their bedrooms.

Some bedroom doors were significantly scratched and marked. One of the communal bathroom's doors had been damaged and then crudely repaired with filler that looked unsightly. Also, the ceiling in one of the bedroom's en-suite bathrooms had been partially removed leaving pipework and electrical wires exposed. The garden was not an attractive space. This was because one of the perimeter fences was damaged and there was litter and broken flower pots strewn over the lawns. Although there was a fish pond this area was littered and also the water was green with mould.

Although the registered persons had completed audits of the accommodation there was no evidence to show that any of these shortfalls had been identified and the registered manager was not able to give us a definite timescale within which they would be addressed. Therefore, we could not be confident that suitable steps would be taken to quickly put things right.

Failure to design, adapt and decorate the accommodation to meet people's needs and expectations was a continuing breach of Regulation 15 (1) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Some of the arrangements for the lunchtime meal we observed taking place in the dining room did not support people to fully enjoy a relaxed and dignified experience. This was because the menu of the day was written in green chalk on a black background and so was difficult for people to see. The dining tables were not attractively laid out and did not have tablecloths and condiments. In addition, drinks were served in plastic beakers some of which were heavily scratched and looked unsightly. These shortfalls increased the likelihood that people would not enjoy their experience of dining in the service leading to them being at greater risk of not eating and drinking enough.

Care staff had not been fully supported to consistently provide care in line with national guidance. In their Provider Information Return the registered persons said that it was important for all care staff to receive thorough introductory and refresher training. They also said that it was important for care staff to receive regular individual supervision to check that they had all of the knowledge and skills they needed. However, records showed that some care staff had not received all of the training the registered persons said was necessary. An example of this was three care staff who had not received refresher training in how to safely

assist people who experienced reduced mobility. There were also examples of some care staff not receiving individual supervision as regularly as was intended. This shortfall had limited the registered persons' ability to establish that all care staff actually had the competencies they needed to care for people in the right way.

These oversights were reflected in the shortfalls we found in the adequacy of the provision made for people to receive safe and person-centred care.
Records showed that all care workers had received refresher training in how best to support people who lived with dementia and who needed extra assistance to express their views and to receive assurance when they were distressed. However, four care staff were not able to demonstrate that they had all of the skills they needed to effectively support people who lived with dementia. We observed a number of occasions when care staff did not recognise that people needed assistance. On one occasion a person who found it difficult to speak tried to attract the attention of three passing care staff because they wanted to give them the core of the apple they had finished eating. On each occasion the member of care staff patted the persons' hand but left them holding the apple core. The person was becoming distressed and so we offered to put the item in the bin after which they smiled their approval. On another occasion we sat beside a person who lived with dementia who had pieces of food over their face and down their blouse. Again, they were becoming anxious because they could not brush the food off their face. This carried on for 10 minutes during which time two care staff spoke with the person but did not recognise the mounting distress the situation was creating. In the end, we asked a member of care staff to address the person's needs. These shortfalls had resulted from some care staff not having the skills they needed to provide the people concerned with the person-centred care they needed to receive.

We recommend that the registered persons consult national guidance about how to ensure that care staff have the knowledge and skills they need to provide enriched social care for people who live with dementia.

Failure to ensure that sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed was a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

National guidelines had been followed to promote positive outcomes for people by seeking consent to care and treatment in line with legislation. The Mental Capacity Act 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The law 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty in order to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

There were suitable arrangements to obtain consent to care and treatment in line with legislation and guidance. The registered manager and care staff were supporting people to make decisions for themselves whenever possible. They had consulted with people who lived in the service, explained information to them and sought their informed consent. Also, when people lacked mental capacity the registered manager had ensured that decisions were made in people's best interests. An example of this was the registered manager liaising with relatives and healthcare professionals when a decision needed to be made about people having rails fitted to the side of their bed. These are sometimes necessary so that a person can rest safely in bed without accidentally slipping and falling onto the floor.

The registered persons had made the necessary applications for DoLS authorisations. Furthermore, they had carefully checked to make sure that any conditions placed on the authorisations were being met. These measures helped to ensure that people who lived in the service only received lawful care that was the least restrictive possible.

People told us they were confident that care staff knew what they were doing and had had their best interests at heart. One of them said, "The care staff here are very good and give me all of the help I need." Relatives were also complimentary about this matter. One of them said, "My family member needs a lot of help and yes they can be quite demanding at times but the staff are very kind and always very patient."

Arrangements were in place that were designed to assess people's needs and choices to ensure that people did not experience discrimination and enjoyed the safeguards established by the Equality Act 2010. An example of this was the registered manager asking people if they had particular expectations deriving from cultural or ethnic identities about how their close personal care should be provided and who should deliver it.

Also, suitable arrangements had been made to ensure that people received effective and coordinated care when they were referred to or moved between services. This included care staff preparing written information likely to be useful to hospital staff when providing medical treatment. Another example of this was the registered manager offering to arrange for people to be accompanied to hospital appointments so that important information could be passed on to healthcare professionals.

People were supported to receive on-going healthcare support. This included senior care staff referring people to see their doctor if they were not well. During our inspection we noted that a senior member of care staff telephoned a person's doctor. This was because they were concerned that the person was not responding well to the treatment prescribed for them. As a result of this a healthcare professional called to see the person to review their treatment. Records also showed that arrangements had been made for people to have consultations with professionals such as dentists, physiotherapists and opticians.

Requires Improvement

Is the service caring?

Our findings

People were positive about the care they received. One of them said, "The staff are very caring. If you want anything, they're there. The staff are all very cheerful, which counts for a lot. You don't see a glum face." Another person told us, "These are good staff. I know them all and I can be myself with them." A person who lived with dementia and who had special communication needs smiled and went across the room to hold hands with a member of care staff when we asked them about the care they received. Most relatives impressed upon us their positive assessment of the service. One of them remarked, "The staff are truly excellent here and I have full confidence in them. I call to the service a lot and I've only ever seen people being treated with real kindness." However, one relative voiced reservations saying, "Yes, on an individual basis the care staff are kind and caring but the regime feels to me like being a holding operation. My family member doesn't get much individual attention other than the basics with washing and dressing. After that I think that they spend most of their day sitting and not being that fulfilled."

Suitable provision had not been made to fully promote people's dignity. One person had not been assisted to properly button up their clothes resulting in them unintentionally exposing their undergarments. On another occasion care staff were assisting someone to move to another room by using a wheelchair even though one of the tyres was flat. This resulted in the person being uncomfortable because the ride was jerky and uneven. A further concern was the insufficient support people who lived with dementia received to handle everyday objects in the right way. Examples of this included a person who was participating in artwork placing their paintbrush in a glass that held their drink. After this the person mistakenly drank from the glass even though a member of care staff was present and could have advised the person against doing so.

Another example was a person who repeatedly tried to use their paintbrush as a straw even though again a member of care staff was present and could have gently intervened to promote the person's dignity. Also, we observed an incident when a member of care staff assisted a person to rise from their chair by pulling upwards on the seat of their trousers. Further examples were instances when a member of care staff was abrupt in their manner and spoke with people in a way that was likely to be experienced as impolite and blunt. In addition, to these examples one person spent long periods of time asleep in their armchair resulting in them sliding into an uncomfortable position with their head resting to one side. During this time there were numerous occasions when care staff were present but none of them tried to address the issue by supporting the person to rest more comfortably.

Some of the arrangements for the lunchtime meal we observed taking place in the dining room did not support people to fully enjoy a relaxed and dignified experience. This was because the menu of the day was written in green chalk on a black background and so was difficult for people to see. The dining tables were not attractively laid out and did not have tablecloths and condiments. In addition, drinks were served in plastic beakers some of which were heavily scratched and looked unsightly. These shortfalls increased the likelihood that people would not enjoy their experience of dining in the service leading to them being at greater risk of not eating and drinking enough.

Suitable provision had not been made to promote people's privacy. This was because one of the communal bathrooms did not have a lock on the door and so could not be secured when in use. Furthermore, we were told that none of the people who lived in the service had been offered the opportunity to have working locks fitted to their bedroom doors. We also witnessed an occasion in one of the communal areas when a member of care staff spoke loudly with a person about their medical condition and in effect disclosed the information concerned to a number of other people who were sitting nearby.

We raised our concerns about these shortfalls with the registered manager who was not able to give us a clear account of the improvements they would make or of the timescale within which they would be completed. Therefore, we were not confident that the service would be developed to ensure that people received the dignified care to which they were entitled.

Failure to ensure that were suitable arrangements to ensure that people consistently received care that promoted their dignity and which was respectful was a breach of Regulation 10 (1) of the Health and Social Care act 2008 (Regulated Activities) Regulations 2014.

On most occasions care staff were considerate and we saw that a special effort had been made to welcome people when they first moved into the service. This had been done so that the experience was positive and not too daunting. The arrangements had included asking family members to bring in items of a person's own furniture so that they had something familiar in their bedroom when they first arrived. Furthermore, records showed that care staff gently asked newly-arrived people how they wished to be addressed and had established what times they would like to be assisted to get up and go to bed. Another example was people being consulted about how often they wished to be checked at night.

Provision had been made to support people to express their views and be actively involved in making decisions about their care and treatment as far as possible. Most people had family, friends or solicitors who could support them to express their preferences. Also, records showed and relatives confirmed that the registered manager had encouraged their involvement by liaising with them on a regular basis. Furthermore, the registered manager had developed links with local lay advocacy resources. Lay advocates are people who are independent of the service and who can support people to make decisions and communicate their wishes.

People could speak with relatives and meet with health and social care professionals in private if this was their wish. Also, care staff had assisted people to keep in touch with their relatives by post and telephone.

There were a number of systems and processes which were designed to ensure that written information was kept confidential. This included paper records that contained private information being stored securely when not in use. Also, computer records were password protected so that they could only be accessed by authorised members of staff.

Requires Improvement

Is the service responsive?

Our findings

People had not been offered sufficient opportunities to pursue their hobbies and interests and to engage in social activities. Although there were two activities managers who were present in the service for a total of 35 hours each week we found that in practice the calendar of social events was poorly managed. We were told that there was a daily programme of small group activities that was complemented by people receiving individual support. However, we only saw two small group events taking place. The first one involved six people most of whom lived with dementia being supported to complete artwork. This was not well organised as most of the people did not receive the assistance they needed to understand what they needed to do. The second event involved three people all of whom lived with dementia playing a game that required them to take turns placing coloured counters in a particular order. However, this activity was also poorly managed because the member of care staff who had been coordinating it was called away. By the time they returned the people had not kept to their turns, were using the wrong colour counters and had scored their progress incorrectly. The activity then continued after the member of care staff returned even though it had no recognisable structure and eventually ended without any conclusion.

We did not see anyone receiving individual support to pursue their hobbies and interests. Also, we observed three people who lived with dementia and who were sitting in the conservatory. We saw them over a period of half an hour and we found that for 95% of the time the people were passive and were withdrawn in their manner. We spoke with two of the people after we had concluded our period of observation and both of them responded positively. They smiled, engaged us in sign-assisted conversation and in so doing demonstrated that they would have benefited from being offered more stimulation than they had received.

We looked at records that were completed each time two people had been supported to participate in a social activity since the start of 2018. One person had completed only seven activities and the other person had completed eight. Furthermore, some of these activities were limited in nature and were unlikely to have provided the people concerned with an enriched social experience. An example of this concern was the fact that six of them had principally involved the person receiving nail care.

The service did not have its own transport and no one could remember the last time people had been offered the opportunity to be supported to access the local community. Also, there was no evidence to show that plans had been made to address this shortfall.

Although in their comments to us people did not express concerns about this aspect of the service they received, we concluded that suitable steps had not been taken to provide people with a range of innovative opportunities to pursue their hobbies and interests.

People said that care staff provided them with all of the practical assistance they needed. One of them remarked, "The staff help me a lot and at the same time they don't take over and leave me to do what I can for myself." Most relatives were positive about the amount of help their family members received. One of them commented, "I know my family member's well cared for because when I call to see them they're neat and smiling." However one relative expressed concerns saying, "Overall, the place is good but recently there

have been occasions when my family member hasn't been helped to put on socks and slippers and they have looked rather dishevelled. I don't call that responsive care at all."

Care staff had prepared a care plan for each person that was designed to describe the practical assistance each person needed and had agreed to receive. The records we examined for eight people confirmed that they had promptly been offered most of the practical assistance they had agreed to receive. This included assistance with washing and dressing, getting about safely and promoting their continence. However, little had been done to present information in care plans in a user-friendly way for people who lived with dementia by using multi-media tools such as graphics and colours. This oversight had reduced people's ability to be fully involved in the process of recording and reviewing the care they received.

We spoke with the registered manager about the shortfalls we had found in the provision that had been made to provide people with person-centred care. Although the registered manager was able to describe the changes they proposed to make, they were not able to give us a clear timescale within which they would be completed. Therefore, we did not have sufficient assurance that the necessary steps would be taken to ensure that people received person-centred care.

Failure to provide person-centred care that was appropriate, met people's needs and reflected their preferences was a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager said that there were robust arrangements in place to enable people to raise concerns or to make a complaint about the service. However, the written complaints procedure did not fully present information in an accessible way. This oversight had increased the risk that people who lived in the service would not be fully informed about how to raise a concern or to make a complaint. We also noted that a suitable record had not been kept of each of the complaints and concerns the registered manager told us had been received since our last inspection visit. This had reduced our ability to check that appropriate steps had been taken to quickly resolve problems in the running of the service.

We recommend that the registered persons consult national guidance about how concerns and complaints can best be managed so that people can be confident that issues will quickly be addressed.

Care staff understood the importance of promoting equality and diversity. This included arrangements that had been made for people to meet their spiritual needs through religious observance. Furthermore, documents showed that the registered persons recognised the importance of appropriately supporting people who chose gay, lesbian, bisexual and transgender life-course identities. This included being aware of how to help people to access social media sites that reflected and promoted their lifestyle choices.

People were supported at the end of their life to have a comfortable, dignified and pain-free death. Records showed that the registered manager had consulted with people about how they wanted to be supported at the end of their life. This included establishing their wishes about what medical care they wanted to receive and whether they wanted to be admitted to hospital or stay at home. Also, there were examples of care staff having kindly supported relatives at this difficult time. This included making them welcome so that they could stay with their family member during their last hours in order to provide comfort and reassurance.

Inadequate

Is the service well-led?

Our findings

At our last focused inspection 21 June 2017 we found that the registered persons had not established suitable arrangements to assess, monitor and improve the quality and safety of the service. This was because the quality checks that had been completed by the registered persons not identified and quickly resolved shortfalls in the running of the service. This included the registered persons' failure to implement all of the fire safety improvements required by the local authority's fire and rescue service.

At the present inspection we found that suitable arrangements had still not been made to ensure that the service reliably met regulatory requirements by learning, innovating and ensuring its sustainability. Although there was a registered manager they had not ensured that quality checks were completed in the right way to quickly put problems right. This had resulted in the persistence of the concerns we have described earlier in our inspection report. These issues included oversights in the provision of safe care and treatment, staff deployment, the completion of background checks on new care staff and the delivery of staff training. Also included were shortfalls in the support some people received to eat and drink enough and the presentation of the accommodation. Furthermore, there were the concerns we noted about oversights in the arrangements made to promote people's dignity and to enrich their lives.

At the present inspection we also found that people had not been fully involved in making improvements to the service. Although there had been regular 'residents' meetings' action had not always been taken to respond to concerns that had been raised. The records of the most recent meeting could not be found and no one could tell us what suggested improvements had been made. Therefore, we looked at the records of the next most recent residents' meeting that had been held on 17 January 2018. At this meeting some people had said that they, 'Would like staff to sit with residents and talk more'. Although there was an 'action note' that assured people that 'one to ones would be completed daily' the evidence we have presented in this inspection report under our domain 'responsive' shows that this commitment had not been honoured. Relatives had been invited to complete quality questionnaires to give feedback about the service. Although most of the feedback had been positive there was no evidence to show that action had been taken to address two people's concerns about specific elements of the care provided for their family members. A relative remarked, "I think that they have too many people living in the service with complex needs due to having dementia and there seems to be no management systems to organise care staff to give people the individual attention they need. I do sometimes feel that the measure of success is only to get through each day without anything serious going wrong."

We spoke with the registered manager about the shortfalls we had identified in the running of the service. They did not appreciate the seriousness of the issues in hand. In addition, they were not able to give us a clear account of the improvements they would make or of the timescale within which they would be completed. Therefore, we concluded that there was no realistic prospect of the required changes promptly being made to ensure that the service provided people with safe care.

Failure to assess, monitor and improve the quality and safety of the services in the carrying on of the regulated activity was a continuing breach of Regulation 17 (1) of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

Care staff told us there was an explicit 'zero-tolerance approach' to any member of staff who did not treat people in the right way. As part of this they were confident that they could speak to the registered persons if they had any concerns about people not receiving safe care. They told us they were confident that any concerns they raised would be taken seriously so that action could quickly be taken to keep people safe. However, we noted that care staff had not identified as a cause for concern the numerous examples poor practice we identified. This lack of insight had contributed to people not always receiving the safe and person-centred care to which they were entitled.

However, people considered that the day to day provision of care in the service was well managed. One of them said, "On balance it's all right. I get all of the help I need and that's all that I care about really." Also, most relatives were complimentary about most aspects of the management of the service. One of them remarked, "Overall, the service is very well organised and the care staff work as a team."

There were a number of systems in place that were designed to help care staff to be clear about their responsibility to provide people with the practical assistance they needed. This included there being a named member of care staff who was in charge of each shift. Also, arrangements had been made for the registered manager and deputy manager to be on call during out of office hours to give advice and assistance to care staff should it be needed. Furthermore, care staff had been invited to attend regular staff meetings that were intended to develop their ability to work together as a team. This provision was designed to ensure that care staff were suitably supported to care for people in the right way.

The service worked in partnership with other agencies. There were a number of examples to confirm that the registered persons recognised the importance of ensuring that people received 'joined-up' care. This included operating efficient systems to manage vacancies in the service. We saw that the registered persons carefully anticipated when vacancies may occur so that they could make the necessary arrangements for new people to quickly be offered the opportunity to receive care in the service.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. We found the registered persons had conspicuously displayed their rating both in the service and on their website.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. CQC check that appropriate action had been taken. The registered manager had submitted notifications to CQC in an appropriate and timely manner in line with CQC guidelines.

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 9 HSCA RA Regulations 2014 Person-centred care The registered persons had failed to ensure that people received person-centred care that was appropriate, met their needs and reflected their wishes.

The enforcement action we took:

We propose to impose a condition of the registration on the registered persons to enable us to closely monitor the running of the service so that people receive safe and person-centred care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered persons had failed to ensure that people were consistently treated with dignity and respect.

The enforcement action we took:

We propose to impose a condition on the registration of the registered persons to enable us to closely monitor the running of the service so that people receive safe and person-centred care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered persons had failed to provide people with safe care and treatment by assessing risks to their health and safety and by doing all that was reasonably practicable to mitigate any such risks.

The enforcement action we took:

We propose to impose a condition on the registration of the registered persons to enable us to closely monitor the running of the service so that people receive safe and person-centred care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment

The registered persons had failed to ensure that all of the premises and equipment used by the service was suitable for the purpose for which they were being used.

The enforcement action we took:

We propose to impose a condition on the registration of the registered persons to enable us to closely monitor the running of the service so that people receive safe and person-centred care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons had failed to establish and operate suitable systems and processes to assess, monitor and improve the quality and safety of the service.

The enforcement action we took:

We propose to impose a condition on the registration of the registered persons to enable us to closely monitor the running of the service so that people receive safe and person-centred care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered persons had failed to operate robust recruitment procedures to ensure that all people employed to work in the service were of good character.

The enforcement action we took:

We propose to impose a condition on the registration of the registered persons to enable us to closely monitor the running of the service so that people receive safe and person-centred care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered persons had failed to ensure that sufficient numbers of suitably qualified , competent, skilled and experienced care staff were deployed in the service.

The enforcement action we took:

We propose to impose a condition on the registration of the registered persons to enable us to closely monitor the running of the service so that people receive safe and person-centred care.