Aria Healthcare Group LTD

Dormy House

Inspection report

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Date of inspection visit:
23 October 2023
02 November 2023

Date of publication:
30 January 2024

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

About the service
Dormy House is a care home providing personal and nursing care for up to 88 people. The service provides support to people who have care needs, such as, diabetes and Parkinson's disease. Some people were living with dementia or had deteriorating mobility. At the time of our inspection there were 60 people using the service.

People's experience of using this service and what we found
Risks associated with people's care were not always managed in a safe way. Incidents and accidents were not always recorded in detail or investigated to reduce further risks. Medicines were not being managed safely and there were times people received as and when medicines with no detail as to why this was given.

People were not always protected from the risk of abuse or neglect as staff were not always reporting or investigating allegations. There were some areas of the service that were not clean or well-maintained, however, we saw in other areas staff practiced good infection control. There were not sufficient staff deployed to ensure people received their care when needed.

Staff were not always supervised in relation to their role and training was not always effective in ensuring good practice. The environment was not always suitable to meet the needs of people.

There were mixed response from people about the quality of the meals. The mealtime experience was chaotic, people at times were served with food that had gone cold.

People were not always supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. The provider has taken action to address this.

There were times when people were not treated in a kind and dignified way. However, we did see examples of staff being caring and considerate. Care plans required more detail around people's life histories and preferences and there was some guidance missing that related to people's needs. Activities for people were lacking.

Complaints were not always investigated, and actions taken to address the concerns. People and relatives were not always confident in the leadership at the service. There was a lack of robust oversight to ensure the quality of care. There were staff that felt they were not always listened to however, other staff said they were starting to feel more supported. The provider has increased the management presence in the service and were working on making and embedding improvements.

The provider operated effective and safe recruitment practices when employing new staff. People had access to health care when needed and assessments of people's care were undertaken before they moved

in.

Rating at last inspection and update
The last rating for this service was good (published 13 May 2021.)

Why we inspected
The inspection was prompted in part due to concerns received about the safe care and treatment of people, and staff levels. A decision was made for us to inspect and examine those risks.

The inspection was also prompted in part by notification of an incident following which a person using the service died. This incident is subject to further investigation by CQC as to whether any regulatory action should be taken. As a result, this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk of choking. This inspection examined those risks.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well-led sections of this full report.

Enforcement and Recommendations
At this inspection we have identified breaches in relation to the safe management of risks, the deployment and supervision of staff, the management of medicines and people not being protected from abuse. We also identified breaches in relation to complaints not always being responded to, the lack of person-centred care planning and lack of meaningful activities. We identified concerns about people not always being treated in a caring and dignified way and the lack of robust oversight.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions, it will no longer be in special measures.

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

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 safe. Details are in our safe findings below.	**Inadequate**
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 responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Dormy House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
Our inspection was completed by 4 inspectors.

Service and service type
Dormy House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Dormy House is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post however, they were absent at the inspection. Instead, we were supported by members of the providers management team.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was asked to complete a

Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 3 people and 11 relatives of people who lived at the service about their experience of the care provided. We spoke with 14 members of staff including the Chief Executive Officer, regional director, managers from sister care homes, care staff, nurses and ancillary staff. We received feedback from 3 external professionals.

We reviewed a range of records including 12 people's care records including daily care notes, multiple medication records, incident records and complaints. We reviewed a variety of records relating to the management of the service including 4 staff recruitment files, spot checks, policies and quality assurance records.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate This meant people were not safe and were at risk of avoidable harm.
Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Where people were at risk of choking this was not always being managed in a safe way. One person was in a lying down position in bed with their lunch plate balancing on their lap. Staff had entered the person's room and had not offered to move them to a better position to eat their meal.
- Another person was supposed to be having a soft meal due to the risk of choking however, the mashed potato looked dry with a crispy film on top. This placed the person at further risk of choking.
- There was a risk people would be given food that was not suitable for them to eat. A member of staff told us they would give 1 person, on a pureed diet, snacks like doughnuts to eat. This would not be suitable to puree due to the texture. During lunch on one floor people's modified meals were pre plated however, they were not named. Staff told us they could tell just by looking at food whose was whose however, there was a risk people would be given the wrong meal.
- One relative told us, "My [family member] is supposed to be on a diet that it moist and not too chewy." They told us their loved one is often given meat that is hard to chew. Another relative told us, "Mashed potato is often very dry and sticks to the roof of [family members] mouth. People can't cut the meat."
- After the inspection the provider confirmed they had reviewed the staff levels around mealtimes to ensure people were more appropriately supported. They told us mealtimes would now be protected and were providing additional training to staff around food consistencies. They were also going to provide additional training to staff around swallowing difficulties.
- Risks associated with fluid intake were not always managed well. One person had a health condition where their fluid intake needed to be restricted to 1000 millilitres per day. We saw from their weekly fluid chart they frequently given nearly double this amount. This placed the person at risk of becoming unwell. We raised this with the provider who has taken steps to address this.
- Where people were at high risk of falls this was not always being managed safely. According to a person's care plan they used a walking frame and stated staff were to be with the person when walking. We observed several occasions during the inspection where the person was walking without staff being with them or observing the person. A member of staff told us, "We have to make a decision whether to accompany a person who is walking and who is at risk, or going to help the person who is slipping out of their chair."
- There was a lack of robust management around accidents and to minimise risks to people's safety. There was a lack of consistency in the amount of detail provided in the recording of the incidents or what actions had been taken to reduce further risk. For example, according to an incident report, 1 person had not had their medicines that day as they had none in stock. There was no information on how this was resolved and whether this impacted the person's health.
- Another incident recorded 1 person had an unwitnessed fall and 'had a major injury sustained.' There was no additional information on what the injury was, how it was treated or any investigation into how it occurred. This was also the same for another person that according to the incident report had been hit by another person whilst walking past them in the corridor. There was no additional information on what

action had been taken as a result. This meant there was no indication of what, if any preventative measures had been put in to place to reduce further risks.

The failure to ensure risks to people's safety were robustly assessed was breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were incidents of clinical risks identified where appropriate management plans were developed to reduce the likelihood of them occurring. People were protected from developing pressure ulcers. One person's records specified they should be supported to reposition in bed to relieve pressure on their skin and this was being undertaken by staff.
● Where people's blood sugar levels need to be checked this was undertaken by staff each day. Staff were knowledgeable on what actions they needed to take if the levels were not safe.
● We observed where people required to hoisted, staff were undertaking this in a safe way to reduce risk of harm to the person.

Staffing and recruitment
● People and relatives told us there were not enough staff. Comments included, "There is not enough staff to cater for the needs of the residents", "There is not enough staff. I came here one day and [family member] had been incontinent, there was just 1 [carer] on their own" and "The nurses are so busy – they're short of staff."
● Throughout the inspection staff were busy and task focused. They had very little opportunity to spend any meaningful time with people. There were times when people at risk of falls were left unattended by staff. During lunch people who needed encouragement and prompting with their meals were not receiving this as staff were too busy.
● Staff told us there were not enough of them to support people. Comments included, "Not enough carers, its chaos", "We have to leave people in the lounge by themselves if we are with someone in their room. We can't cover all that is going on" and "Don't think there is (enough staff). The residents and staff suffer because of it. They (people) don't get enough attention."
● The provider ensured absence with staff, were filled with agency staff. However, staff raised concerns that agency were not always regular and agency staff were not familiar with people's needs. One member of staff told us, "It puts permanent staff under excess pressure. For residents I don't think the care is then 100 percent and it can put them at risk."
● One external professional told us, "Not enough staff and not enough permanent staff. I can give instructions but return the next time and have to explain it all again because it's different staff." Another said, "Often in the lounge it can be left unattended if the one member of staff has to take a resident to the bathroom."

The failure to ensure there were appropriate levels of staff deployed at the service was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The provider operated effective and safe recruitment practices when employing new staff. This included requesting and receiving references and checks with the disclosure and barring service (DBS). DBS checks are carried out to confirm whether prospective new staff had a criminal record or were barred from working with people.

Using medicines safely
● Medicines were not always being managed in a safe way. Where people required 'as and when' medicines there were not always guidance in place for staff on when this should be given. For example, we saw from 1

persons Medicine Administration Record (MAR) they had been administered more than 30 doses of an 'as and when' antipsychotic medicine. There was no guidance for staff on when this should be given, and staff had only recorded the reasons for giving this on 2 occasions. The provider has ensured the guidance is now in place and has requested a medicine review with the GP.

● Stocks of medicine were not always counted by staff which meant there was a risk people may not receive their medicine as it may have run out. One person's MAR stated there were 68 tablets in stock however, there should have been 120 based on what had been received. A member of staff told us the excess was kept elsewhere but these had not been included in the stock count or checked by staff. This placed the person at risk of running out of the medicine if staff were not checking there was sufficient in stock.

● Another person had a prescription for pain relief that contained paracetamol, to be given 'as and when' needed. There was guidance in place on when this should be given that stated paracetamol should not be given in addition to this. However, there was a separate MAR for paracetamol and there was a risk the member of staff may administer paracetamol not knowing the person had already been given the alternative pain relief. The member of staff removed paracetamol from the MAR once we had highlighted this.

● The pill crusher was dirty, badly cracked and had a large residue of other medicines. There was a risk people's medicine would be contaminated with other medicines. Before the end of the inspection a new pill crusher had been put in place.

● We were made aware the lift to one of the units had been broken since 12 October 2023. This meant staff were unable to take the medicines trolley in the lift. However, we observed a member of staff dispensing all people's medicine into a pot downstairs and carrying it up the stairs. This is not in line with NICE guidance where each person's medicine should be dispensed one at a time. We fed this back to the provider who arranged for the medicine trolley to be taken upstairs.

● We asked a member of staff how they would count the remaining stock of medicine in bottles. They tipped the medicines in their hand, without washing them first, which could contaminate the medicine. They also had not considered the use of a 'counting triangle' to prevent having to touch the medicine. The provider organised for one to be purchased.

● There were gaps in people's MAR which meant there was a risk the person had not received their medicine. For example, 1 person's MAR showed gaps for 3 occasions and it was not clear from the remaining stock (as counts were not accurate) whether this had been given.

The failure to ensure medicines were managed in a safe way was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● There was a mixed response from people about whether they felt safe. One person told us, "I feel safe as everyone helps you." Whilst another told us they didn't feel safe and, "I worry staff won't turn up when I shout." Comments from relatives included, "I would hope she [family member] is safe but care is just adequate", "I feel [loved one] is safe there" and "There is neglect there and it is not acceptable."

● People were not always protected from the risk of abuse. Although staff had received safeguarding training, they were not always recognising safeguarding incidents or reporting alleged abuse. Two members of staff told us a person had alleged another person had hit them. The victim was found on the floor with an injury however, the incident form staff completed did not include the allegation but just they had fallen.

● We saw from care notes another person had alleged the same perpetrator had hit them across the face. Whilst it was recorded the victim received care and support, no investigation or action was taken to reduce further risks to people.

● It was recorded that another person had sustained an injury to their arm and forehead. There was no record of any investigation to determine how the injuries occurred to the person to reduce further risks.

● The provider and registered manager failed to report all safeguarding incidents to the local authority safeguarding teams in line with legal requirements.

The failure to ensure people were protected from the risk of abuse was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● We found some areas of the service where staff were not adhering to good infection, prevention control. All the sluice rooms had been left unlocked and were accessible to people. The sluice rooms were not clean or well maintained. We found the medicine room sink and surround were badly degraded and dirty. We fed this back to the provider who told us they would address this.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was responding effectively to risks and signs of infection.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

The provider was facilitating visits for people living in the service in accordance with the current guidance.

Requires Improvement

Is the service effective?

Our findings

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

At our inspection in November 2019, we rated this key question good. The rating for this key question has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- We received mixed feedback from people and relatives about the effectiveness of staff. One relative told us, "Some [staff] are better than others" whilst another told us, "I feel more training is needed on the very basics of care."
- Staff fed back they did not feel supported with their ongoing professional development. Comments included, "I received no support. Guidance was lacking", "I think I had supervision this year or last year, support? There's not much", "I did raise in my one to one how unhappy I was, but nothing changes" and "Sometimes they [supervisions] happen but my questions have not been answered in the past, so they have not helped. It ticked their form."
- We saw from the supervision matrix that out of 36 nursing and care staff only 3 had received a one to one supervision this year. We noted 17 out of 36 staff had been part of a group supervision and 17 had not received either a group or one to one supervision.
- Where supervisions were taking place, this was not always effective in identifying shortfalls in staff practice. We identified gaps around the recording of people's incidents, the management of risk, medicines management and safeguarding. These were areas for development that could have been addressed during supervisions.
- Staff were provided with training around the needs of people including dementia. However, the training was not always effective in ensuring staff were competent to provide appropriate care. We found examples through the inspection where staff were not providing the appropriate support to people when at a heightened state of anxiety.

The failure to ensure staff were suitably trained and supervised in their role was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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

- The provider had not ensured the environment suited the needs of people living with dementia. There was a lack of appropriate signage to help orientate people. We observed 1 person going into other people's rooms. A relative told us they also struggled to find their way around and said, "It is difficult for us to move around, imagine for the residents." The memory boxes placed outside of people's rooms were mostly empty.
- There were people that walked with purpose yet there was a lack of space or any destination areas for them. We observed 1 person walking up and down the corridor throughout the inspection with very little meaningful sensory items to interest them.

● We were made aware the lift to one of the units had been out of action since 12 October 2023. This meant that people that were unable to use the stairs were limited to staying in their bedroom. Sufficient action had not been taken to reduce the risk of isolation as there was no communal space available to people. One person told us how this impacted them, that they were lonely and did not like being in their room all the time. After the inspection the provider confirmed an empty room had now been set up as a communal space for people whilst they were waiting for the lift to be repaired. They told us, "I understand it should have been done sooner. I don't know why it wasn't picked up on."
● The standard of the maintenance and décor of the building varied greatly. The initial communal areas had been refurbished whilst upstairs in 1 unit and some other areas of the service were not to the same standard. The paintwork was chipped and scrapped, the flooring was dirty, and furnishings were old. One relative told us, "The room is awful. It's a horrible room and I don't think [loved one] is going to have it done up."

The provider had failed to ensure the environment was set up to meet the needs of people is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● There was a mix of responses from people and relatives on the quality of the food. Comments included, "The food is lovely – I'm putting on weight", "Food, its sometimes nice but other times leaves much to be desired" and "[Family member] doesn't get choices and food needs to be pureed and it does not look appetising."
● We observed lunch being served in all the areas of the service. Whilst there was an attempt in one section to play music and offer visual choices this was not the case in other areas. In one section 2 members of staff were with 8 people, 6 of whom needed support with their meals. Staff were not talking with people and both staff at different times left the room whilst in the middle of supporting a person with their meal. People were left waiting for support which would have meant their meal was cold by the time they ate it.
● In another area a member of staff was giving 1 person their meal in their room. They were interrupted twice to respond to a person's call bell meaning the person kept having to wait for their meal. We observed nurses were also interrupting people's meals to give their medicine.

We recommend people are provided with appetising and nutritious meals and are appropriately supported at mealtime.

● The provider has confirmed mealtime was now protected and only medicines that are required are to be given when people are having their meal. They have also confirmed additional staff will be available to support people during meals. They are also having discussions with the chef to ensure people are involved with menu options.
● Staff were aware of people that were nutritionally at risk and took steps to address this. For example, people were on a food and fluid charts, higher calorie snacks were provided, and guidance was sought from health care professionals.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, 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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● Where decisions were being made for people, there was not always evidence their capacity had been appropriately assessed. This particularly related to people that had sensor mats to alert staff. There were no assessments of the person's capacity to agree to this restriction to determine whether this was in the person's best interests' or whether less restrictive measures had been considered. The regional director told us in relation to this, "There is some work to be done, that work is ongoing."
● In other areas people's rights were protected because staff acted in accordance with MCA. We saw from the care plans that where people's capacity was in doubt assessments took place along with clearly recorded best interest decisions. Examples of these related to consent to living at the service and having bed rails. Where appropriate, applications had been submitted to the local authority for authorisation.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care; Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People told us they were able to access health care at the service and this was also confirmed with relatives. One person told us, "They have nurses, you can tell them if you're not well."
● Staff reviewed people's health continuously and if they had a concern, they would either speak the with nurses or contact health care professionals to gain advice.
● We saw evidence of visits from various health care professional including opticians, community nurses, hospice nurse, physios and occupational therapists.
● An assessment of people's needs was undertaken before they moved into the service. The assessments included information about communication, allergies, medical background, weight, dietary needs, mobility, memory and cognition. Information from the pre-assessment was then used to develop care plans for people.
● Staff used recognised good practice and national tools to ensure that people's care was provided appropriately. For example, staff used a 'Waterlow pressure ulcer risk-assessment tool' to review the risk of developing pressure ulcers.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our inspection in November 2019, we rated this key question good. The rating for this key question has changed 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; Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care

- People did not always feel staff were kind and caring. One told us, "Its diabolical (living here). Some carers are good, other ones are awful. One is superb and caring." One relative told us, "It's a job for them [staff], can't think of anyone that goes out of their way. Some just do their job."
- We found instances during the inspection where people were not always treated with dignity and respect. During lunch we observed staff standing next to people whilst supporting them. At times staff would stand between 2 people and alternatively offer a spoonful of food which was not dignified.
- Staff did not always consider people's individual needs. One person was anxiously calling out all day, but despite their care plan stating they loved music to help calm them, staff did not play music at all during the day.
- We observed there were multiple people that looked unkempt, and their hair was dirty. People and relatives raised concerns that baths, showers and hair washing was not always being offered. One person told us, "They are supposed to offer a shower every morning, but I can't remember the last time I had a shower." A relative told us, "I don't think [family member] has had a bath since X has been here and X hair was disgusting. [Family member] appearance is awful."
- One external professional told us, "More care should be taken on the overall appearance of the resident, clean glasses, teeth and hair brushed." A member of staff told us, "There are times when we don't wash their hair."
- The provider had not considered the emotional impact on people unable to come downstairs when the lift was out of action. No additional staff had been placed onto the unit to ensure people were not socially isolated. One person told us, "They [staff] always say they will come back but the never do."

The provider had failed to ensure people were always treated with dignity and respect and were always given choices around their delivery of care this was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Despite this people fed back very positively about the caring nature of other staff. One person told us, "The staff are nice. They come when I need them." A relative said, "Can't fault the staff, they are all lovely." One visiting professional told us, "I do feel the majority of staff are kind and caring towards the residents."
- We observed some examples of staff being considerate and kind to people. One member of the staff went to find a person to say goodbye. The member of staff told us they always had a good chat with the person

and liked to say goodbye when they went off duty.
● There were staff that greeted people warmly when they went into their rooms, and we saw this was appreciated by people.
● When personal care was being delivered staff always ensured the bedroom or bathroom door was closed to protect the person's dignity.

Requires Improvement

Is the service responsive?

Our findings

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

At our inspection in November 2019, we rated this key question good. The rating for this key question has changed to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

- Care plans contained some information on the likes and interests that people had but this was not consistent. There was information missing on people's preferred routines and their life histories. This meant there was a risk staff would not provide person centred care.
- There was not always sufficient and up to date guidance in the care plans around the specific needs of people. This meant that there was a risk that staff would not deliver the most appropriate care. For example, according to 1 person's care plan they could become agitated and resistant to personal care. There was no specific guidance for staff on how best to comfort and reassure the person.
- Where guidance was in place staff were not always following this. One person's care plan stated when they were anxious or agitated, they would display a particular behaviour. The care plan stated staff were to engage the person in meaningful activities that could include washing dishes or walks in the garden. However, the care notes frequently recorded the person was just offered a drink and taken to their bedroom.

- Carers daily notes lacked personalisation and were brief and repetitive. There was little variation between entries, and some entries were more detailed than others. Care notes were not person-centred and did not offer a description of what the person's day was like, or reflective of what activities they took part in or were encouraged to participate in. One health care professional told us, "Staff are working hard just to get the basics done."
- People's end of life care plans were not inconsistent around people's wishes nearing the end of their life. Whilst some had some good detail others just stated the person wanted to remain comfortable.

The provider failed to ensure care and treatment was always planned that met people's individual and most current needs. This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 and relatives told us there was not sufficient meaningful activities taking place in the service. Comments included, "They just sit in front of a telly and that's it", "No activities happening, she is always just sat in a chair in the middle of the room, activities are so important", "Have a few singalongs and they take them downstairs but that's only randomly" and "There's no quality of life there."
- Throughout the inspection there were limited activities taking place other than a member of staff playing a game with a person. People looked bored and frequently falling asleep in their chair.
- One external professional told us, "Activities are very limited when go in I find that what is on the television

is not appropriate so put on something more suitable, but that could be running all through the day and nobody will think to put on something else." The provider told us they were recruiting an additional dedicated activity staff.

The provider failed to ensure care was always provided that met people's individual interests and needs. This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

● People and relatives were not confident their concerns would be listened to, and actions taken. One relative told us, "I complained but it happened again."

● There was a lack of robust investigation into the complaints or actions taken to make the necessary improvements. A relative told us they had made a complaint to the registered manager about the quality of safety of care their loved one received. They provided us with a copy of this complaint however, this was not recorded in the complaints folder and there was no evidence of an investigation into this.

● Another relative told us they had made a complaint in relation to the quality of meals and staff levels. Although they stated the registered manager addressed some of this there was no record of this in the complaints folder.

The provider failed to ensure complaints and concerns were always investigated and appropriate action taken which was a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● There was inconsistency around how people were being supported with their communication needs. One relative told us, "They lost [family member] glasses, and the hearing aid is rarely put in."

● Whilst some care plans detailed how staff should speak with a person others lacked this information. One care plan stated the person may become 'muddled' however, there was no guidance on how staff should present information to the person.

Inadequate

Is the service well-led?

Our findings

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

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

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● People and relatives were not confident in the leadership at the service. Comments from them included, "The home is not meeting the standards we expect. Stimulation, care and food is just not up to standard. The management talk the talk but no actions" and "I did not feel supported at all with the previous management and when I did raise issues, nothing really improved."
● The communication between the staff teams and the management was lacking which impacted on the care delivery. For example, staff had not informed the management team of the concerns regarding either the medicine trolley or housekeeping trolley being downstairs and the impact of this when the lift was broken. A member of staff told us of communication, "I don't feel there is any, not really. We all work independently."
● A relative told us, "The communication is not very good. [Family member] room is not always clean, and I end up doing it despite me having already raised it." Another said, "The problem is communication, they don't work as a team."
● Internal quality assurance systems and processes to audit or review service performance and the safety and quality of care were not operating effectively. These had not always identified or prevented issues occurring or continuing at the service.
● For example, we reviewed the medicines audit for 30 September 2023 that scored 95%. The audit had not identified the dirty degrading sink in the medicine room, PRN guidance missing (aside from 1), the dirty pill splitter and lack of stock counts.
● There was a lack of oversight of risks associated with people's care including the risk of choking and the deployment of staff. The provider told us, "Clinical risk management and oversight has not been happening."

The failure to ensure quality assurance and governance systems were effective was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● Before the inspection, the provider had increased the management resources to support staff at the service. During and since the inspection the provider has taken action to address some of the shortfalls with plans to embed further improvements. One external professional told us, "I do feel that the management I'm speaking to at the moment are listening to me and my concerns." A member of staff told us, "The

[management team] is listening, so I hope they stay a while. [They are] accommodating and listen. Trying to work together."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

● People did not always have an opportunity to feedback on any improvements they wanted at the service. The last resident meeting took place in February 2023. The survey completed in September 2022 identified only 4 people had completed this with an action on how more feedback could be obtained. There was no evidence of how this was going to be addressed.

● Whilst relatives meetings took place, relatives did not always feel that changes took place when they raised things. We saw from the September 2023 meeting that concerns were raised around staff levels and the dining experience for people. Both these concerns remained at the inspection.

● This theme was also raised on the last relative survey in September 2022 where a third of the completed surveys raised concerns with the quality of the food and the mealtime experience. It was also raised that not all relatives were invited to relatives' meetings. One relative told us, "I didn't know anything about the relatives meeting." The survey recorded that overall, 40% of relatives felt the home 'required improvement'. However, no outcomes had been completed to show what actions were being taken to address this.

● Staff told us they did not always feel supported or valued although some told us things were starting to improve. Comments included, "At staff meetings no one says anything because nothing changes; you don't feel listened to", "I do not feel supported (by management). Annual leave is denied and there is no point in saying anything in staff meetings" and "It is not a good culture here. Managers need to understand where we are coming from. It tells on you physically, mentally and emotionally. Last few weeks we can say they have tried with the staffing, and it feels someone is starting to listen."

● We saw from the staff survey forms for July 2023 it identified there was low morale with staff and they did not feel supported. The actions from this recorded, 'Ensuring that meaningful discussions within supervisions are held with all colleagues around their development and training.' However, this action had not been completed as supervisions were still not taking place.

The failure to ensure the service performance was evaluated and improved was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

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; Working in partnership with others

● We noted from incident reports that relatives had not always been provided with accurate information when an incident or accident occurred with their loved ones. For example, 1 person had sustained an injury to their head. According to the report the relatives had not been informed that the person had alleged this incident occurred as they had been pushed over by another person.

● The registered manager had not always ensured they had shared information with funding authorities regarding service users being harmed to ensure there was an adequately informed review, investigation and actions agreed to help avoid or prevent these issues happening again.

● 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. The registered manager had not informed the CQC of all significant events including incidents and safeguarding concerns. This included the lift to one of the units being broken and incidents of alleged abuse.

The failure to ensure the service worked in partnership effectively with other relatives and agencies is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The provider failed to ensure care and treatment was always planned that met people's individual, interests and most current needs The provider also failed to ensure the environment was set up to meet people's needs. .

The enforcement action we took:

We imposed a condition on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	The provider had failed to ensure people were always treated with dignity and respect and were always given choices around their delivery of care.

The enforcement action we took:

We imposed a condition to the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider failed to ensure that risks, including medicines were managed in a safe way.

The enforcement action we took:

We imposed a condition on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment
Treatment of disease, disorder or injury	The provider failed to ensure people were protected from the risk of abuse and neglect.

The enforcement action we took:

We imposed a condition on the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints
Treatment of disease, disorder or injury	The provider failed to ensure complaints and concerns were always investigated and appropriate action taken.

The enforcement action we took:

We imposed a condition on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider failed to ensure robust oversight and evaluation of care delivery.

The enforcement action we took:

We imposed a condition on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Treatment of disease, disorder or injury	The provider failed to ensure there were sufficient suitably trained and supervised staff deployed at the service.

The enforcement action we took:

We imposed a condition to the providers registration.