St. Cloud Care Limited

Chestnut View Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Chestnut View Care Home is a care home providing personal and nursing care for up to 60 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 42 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 safely particularly relating to moving and handling, people who were unable to use call bells and oral health care. Other risks were managed well including wound care and people that were nutritionally at risk. Aspects of the management of medicines were not safe.

People fedback they had to wait long periods of time before their call bell was answered and this was confirmed through checking call bell records. We found staff were not always deployed effectively to ensure safe delivery of care. Parts of the service were clean and tidy however we found some aspects of infection control needed improvement.

Detailed assessments of people's needs and preferences were not always undertaken before people moved in. Care plans also lacked information around people's life histories and preferences. End of life care was not planned appropriately.

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

People were not always treated in a caring and dignified way. However, we also observed instances where staff were kind, caring and respectful to people.

Whilst staff received training this was not always effective in ensuring good practice. We have made a recommendation on this. Staff said they felt supported. Nurses were provided with effective clinical supervisions.

There was a mixed response from people about the quality of the food. People were not always involved in decisions around the meal options.

Complaints and concerns were not always taken seriously, and changes were not always made when concerns were raised.

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 felt valued and supported.

The provider operated effective and safe recruitment practices when employing new staff. People had access to external health care and staff followed guidance from the professionals.

People had access to meaningful activities both inside and outside of the service.

Rating at last inspection and update
The last rating for this service was requires improvement (published 29 December 2021)

Why we inspected
The inspection was prompted in part due to concerns received about the safe care and treatment of people, infection control, staff levels and people not always being protected from abuse and neglect. A decision was made for us to inspect and examine 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 report.

Enforcement and Recommendations
At this inspection we have identified breaches in relation to the safe management of risks, the deployment of staff and the management of medicine. We also identified breaches in relation to the assessment of people's care needs, complaints not always being responded to, and people's capacity not always being assessed. We identified concerns about people not always being treated in a caring and dignified way and the lack of robust oversight. We have made two recommendations, that the provider improves how they support people with dietary needs and that the provider reviews the assessment of staff competencies to ensure safe and effective delivery of care.

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

Follow up
We 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 always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Chestnut View Care Home

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 5 inspectors.

Service and service type
Chestnut View Care Home 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. Chestnut View Care Home 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.

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. We used all this information to plan our inspection.

The provider was not 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.

During the inspection
We spoke with 14 people and 12 relatives of people who lived at the service about their experience of the care provided. We spoke with 18 members of staff including the registered manager, the regional manager, the nominated individual (The nominated individual is responsible for supervising the management of the service on behalf of the provider), care staff, nurses and ancillary staff. We received feedback from 4 external professionals.

We reviewed a range of records including 11 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 6 staff recruitment files, spot checks, policies and quality assurance records.

Requires Improvement

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

Assessing risk, safety monitoring and management

● Risks associated with people oral health care were not always managed in a safe way. One person required support from staff to brush their teeth however this was not consistently taking place. Staff said the person at times refused the support although this was not being recorded as such. As a result of lack of oral hygiene, the person had lost a tooth and had developed sores in their mouth which had not been identified by staff. Staff had not identified the person had lost their tooth and it had been identified by a family member.

● Moving and handling risk assessments for people were not accurate and there was a risk people may not be supported in the safest way. In one part of a person's care plan it stated 1 member of staff was needed to support the person to transfer. However, another part of the care plan stated 2 staff were required. There was also conflicting information on whether the person required a standing hoist or just their walking frame. We observed this person being inappropriately lifted by the trousers and under the person's armpit to move them from their wheelchair to an armchair. The provider has confirmed this has been reported to the Safeguarding team at the Local Authority.

● Where people were unable to use call bells, the assessments in place were not detailed with sufficient guidance for staff on how best to manage this. For example, one risk assessment stated the person was unable to use the bell and a sensor mat was also in their room. This was not mitigating the risk of the person not being able to alert staff if needed.

The failure to ensure risks to people's safety were robustly assessed was a repeated breach of regulation 12 (1)of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Other risk management was undertaken in a safe way. People at risk of falling out of bed had their beds fitted either with bedrails or were sleeping on a low bed. The bedrails were fitted with bumpers to prevent entrapment and there were bedrails assessment and risk of falls assessment in place. One relative said, "When she was at risk of falling, they put mats there which alert them when she has got out of bed."

● Aside from the above concern with moving and handling we saw other people being supported by other staff in a safe way using moving and handling equipment. One relative told us, "There are 2 people helping her all the time to move."

● Equipment was available to assist in the evacuation of people. Fire exits are clearly marked and free from obstruction and fire evacuation plans were displayed throughout. All people had up to date personal evacuation plans to guide staff on how to support people to evacuate in a safe way.

● Where clinical risks were identified 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.

Staffing and recruitment

● There were people on the ground and top floor that told us there were not always sufficient staff deployed to support them. Comments included, "They could do with 1 or 2 more at peak times. It's more when they are getting people up. Sometimes I have to wait" and "I would say they don't have enough staff."

● One person told us, "If I want to go to the [toilet] sometimes it's an hour before somebody comes. An hour and ten minutes the other day." Their call bell record confirmed this.

● We noted there were only 2 staff on one of the ground units where the registered manager told us 3 staff were required. We observed 1 person crying out to be supported to go to the toilet however there were no staff around to hear them. We intervened and used the call to alert staff and a senior carer from another floor came to support them.

● Staff told us they did not always have time to offer people baths and showers. One member of staff confirmed they had been unable to offer anyone a bath or a shower on the morning of the inspection. They told us, "Its honestly not enough [staff], it's having a bit of an impact." We saw from people's bathing and showering records often people had only been offered 1 shower or bath a week. One person told us, "I haven't had a bath or a shower, it's not a nice feeling." A member of staff told us, "We have to schedule in baths and showers to make sure we can fit them in."

● Throughout the inspection staff in some areas of the service were busy and task focused. They had very little opportunity to spend any meaningful time with people During lunch on one floor people who needed encouragement and prompting with their meals were not receiving this as staff were too busy.

● One relative said, "Staff do an amazing job, but they are stretched to the eyeballs, and there can be times when the afternoon cup of tea is forgotten about."

● There was a mixture of responses from staff on whether they were sufficient staff to support people. Some comments were positive including, "Staffing has improved and there is less agency now" and "I never feel we are short of staff; I have time enough to help people." Whilst other staff commented, "[At night] I think it would be very beneficial to have at least 1 other member of staff. It's a big building for 6 members of staff to manage" and "There is plenty to do so what worries me is that there was not enough [staff] and things were getting missed or pushed to the next day."

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

● There were people and relatives that fed back positively about the staff levels. Comments included, "I can call staff with my call bell, and they will come quite quickly", "There is always a staff member around who pops in to say hello and check Mum is okay" and "I have never been in and seen people waiting for heard call bells ringing and ringing."

●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

● Whilst most people received their medicines as prescribed, there were elements of the management of medicines that were not undertaken in a safe way. One person was prescribed a medicine for sores in their mouth however staff had not added this to the medicine administration record (MAR) or care records. There was a risk the person would not receive this medicine. The member of staff added this to the MAR before the

end of the inspection and confirmed the person had now received their medicine.
● On the day of the inspection a member of staff told us they had administered ear drops into a person's eye. We confirmed the person did not come to any harm.
● One person had been given 20mls of their antihistamine on the same day however the maximum daily dose should be 10mls. This meant the person had been overdosed. We raised this with the provider who has reported this to the safeguarding team. They also advised us they would undertake an investigation into this.
● Multiple MARs did not include the stock balances booked in or carried forward. There was a risk a medicines would run out as these had not been counted and the provider was unable to audits the medicines accurately.

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

● Other areas of the management of medicines were managed well. Each MAR had a recent dated photo, details of how the person preferred to take the medicines, details of allergies and GP details.
● Where people were on time sensitive medicines staff ensured they received this at the correct times. Where people had medicine patches, staff ensured they alternated the site of application to reduce the risk of irritation to the person's skin.

Preventing and controlling infection
● We found some areas of the service where staff were not adhering to good infection, prevention control. All the of the sluice rooms had been left unlocked and were accessible to people. The sluice rooms were not clean or well maintained. We observed staff were not washing their hands before leaving the room despite leaving soiled continence aids in the bins in there. We fed this back to the regional manager who addressed this with staff.
● In the laundry room there were bags washing with soiled and non-soiled items all stacked onto each other There was an armchair cushion soiled with faeces only partially placed inside a red bag and left on the floor. There was also a strong urine smell inside the room. This placed people at risk cross contamination. The regional manager told us they had unexpected absence of cleaning staff. Before the end of the inspection, they organised for all the laundry to be picked up by a sister home to be cleaned.
● The absence of a member of cleaning staff had also impacted on the general cleanliness of some other areas of the home. This included carpets in people's rooms that had a lot of food debris. During the inspection an agency cleaner had arrived in the home and was undertaking cleaning.
● 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.

Systems and processes to safeguard people from the risk of abuse
● The provider managed incidents appropriately, put measures in place to protect people but they didn't report all safeguarding incidents to the local authority safeguarding teams in line with legal requirements. We saw from the incident records that people sustained skin tears and experienced falls. However, the local authority confirmed not all of these had been reported to them. We fed this back to the provider who will take steps to address this.
● People fed back they felt safe with staff. Comments included, "Staff are kind and friendly" and "On the

whole I can say that I am safe and well looked after here." Comments from relatives included, "[Family member] is definitely safe. I have nothing but respect for the people who work here" and "I go to bed without worrying how my [relative] is."

● Staff understood what they needed to do to protect people from the risk of abuse. Comments from staff included, "[Abuse] It can come in many forms. It must be reported to line manager. I am aware of some behaviours which would make me question abuse – sudden changes in behaviour, loss of appetite; changed sleeping pattern; unexplained bruising" and "Would report to team leader have to inform senior in charge straight away and make a statement."

● Staff received safeguarding training and there was a whistleblowing policy that staff could access. Aside from reporting falls and all skin tears to the Local Authority, the registered manager had investigated all other allegations of abuse.

Learning lessons when things go wrong

● Incidents and accidents were recorded with action taken to reduce further occurrences. We reviewed the incident and accident reports and found that steps had been taken to reduce the risks. For example, a person had fallen several times over a few days. The person was referred to the appropriate health care professionals and a sensor mat had been placed in their room. We noted their falls had reduced as a result.

● Staff understood their responsibility to report incidents. One told us, "As soon as [I would notice a concern], I will inform the nurse on duty, take picture and record on [care system]. I will inform deputy as well. GP may come. Every week we do audit of skin integrity as well."

● Senior staff and management undertook weekly meetings to discuss and review people who were clinically at risk. Where actions were identified these were reviewed regularly for example in relation to wound care and people that were nutritionally at risk.

Visiting in care homes

The provider was facilitating visits for people living in the service in accordance with the current guidance. One relative told us, "They had no problem with us dropping in at any time."

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 June 2021, we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- Before they moved into the service, assessments of people's needs were not always undertaken in a meaningful way. The registered manager had undertaken 2 pre-admission assessments. One had information missing around the person's preferences on bathing/showering, whether they preferred a male or female carer, social history and hobbies. The registered manager told us they did not speak with the person but took the information from a member of staff at a previous care setting. This meant the person, despite being able to voice their wishes and preferences had no opportunity to be involved in discussions about what their needs and preferences were.
- The second assessment completed by the registered manager had the person's name incorrectly recorded. There was no information relating to medicines they had been prescribed, whether the person needed support with moving and handling, any history of falls or whether there was any nutritional support needed. Other areas that were not explored on the assessment included what type of continence aids the person required. The registered manager could not be assured they would be able to fully meet all the needs and preferences of the person before the person moved in.
- Where people had been admitted from hospital, staff were relying upon an assessment of the person's needs undertaken by the hospital staff. Although this included detailed clinical information there was limited information on the person's preferred care routines, likes, dislikes, cultural and religious needs and their social history. Despite their policy stating that this information needed to be assessed alongside hospital assessments.

As people's needs were not always assessed around their needs and preferences this is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- There were reviews of people's care that were undertaken which outlined individual's care and support. For example, their preferred routines, personal hygiene, health, dietary needs and sleep patterns. People and relatives told us they were involved in these reviews.

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. For example, a capacity assessment was undertaken for 1 person where it was deemed, they lacked capacity to consent to living at the service. The person also required a sensor mat and the capacity assessment for this stated they were able to consent and had signed a consent form. Both assessments were undertaken on the same day and contained conflicting information.
● The same person also had a low bed which restricted them from being able to stand up from bed. There was no assessment 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.
● Another person used a bed with bed rails. Their capacity assessment was only partially completed and there was no conclusion recorded as to the person's ability to consent to this. This was also the case for their capacity assessment in relation to living at the service. There were however capacity assessments and best interests meeting recorded in relation to the person being given medicine covertly [disguising it in food or drink without the person knowing].
● Not all staff were familiar with the principles of MCA but had an understanding that they needed to ask consent from people.

The failure to ensure the principles of the Mental Capacity Act 2005 were consistently followed was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● There were other incidences where people had restrictions that had clearly documented capacity assessments and best interest meetings recorded. This included who those discussions had taken place with for example family and health care professionals. This related to the use of bed rails, living at the service and sensor mats. Appropriate DoLS applications had been made to the Local Authority. One member of staff said, "We really really need to understand people's mental capacity – everyone has some level of capacity to make a choice in some area."

Staff support: induction, training, skills and experience
● Whilst all staff had received training and supervisions this was not always effective in ensuring staff were competent in delivering the most appropriate care. We identified some poor practice around the management of medicines, moving and handling and understanding the principles of MCA. We have asked the provider to review how staff are competency assessed once training has been delivered.

We recommend the provider establishes an effective way of assessing staff competencies to ensure safe and effective delivery of care.

● We did observe instances of staff delivering effective care particularly clinical care. The nursing team received clinical supervisions from an experienced clinician to promote the nurses' effective clinical standards. This included the substantive and regular agency nurses. One member of staff told us, "We are expected to prepare a form with any topic for discussion, this could be any ideas for my development, it's pretty good really."

● Staff were complimentary of the quality of the training they received. Commented included, "It was very good [induction]" and "I have done lots of training in lots of areas, for example dementia. All training has been very helpful to me doing my job. Got plenty of guidance during my induction."

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

At the inspection in June 2021, we found people were not supported to eat and drink enough to maintain a balanced diet. This was a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection the provider had made improvements and was no longer in breach of regulation 14. However, there were still some areas to improve upon.

● People gave mixed comments on the quality of food being provided. Comments included, "The food is ok, I can choose from two options", "The food is terrible" and "The food is alright, I think the kitchen does not find making vegetarian food easy." Comments from relatives included, "The food is very good, I can't knock that", "She loves the food" and "The food, he was given a soft diet, it always looked nice and smelt nice, you'd want to eat it."
● We observed during lunch that people left large portions of their meal. One member of staff told us, "Food [we need], more varieties, quality is fine but not always different choices available. This needs to be improved."
We recommend the provider offers people a choice of nutritious and appetising food that suits people preferences.

● At the previous inspection we found people's nutritional and hydration needs were not assessed appropriately. At this inspection this had improved. 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. Other people were offered modified diets where needed. One person told us, "Staff think I don't drink enough so they keep encouraging me to drink more." A relative told us, "At one stage she [family member] lost a lot of weight which has been put back on."

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

At the inspection in June 2021, we found people living with dementia did not live in an environment that met their needs. This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements and the provider was no longer in breach of this regulation.

● Since the inspection in June 2021 people who lived with dementia had moved to a more purpose-built environment. The wardrobes and cabinets had a clear panel, so people were able to easily see what was inside. There were picture signs on the doors to help orientate people including on the bathrooms and toilets.
● The flooring of the communal areas and the hallways were plain in colour to reduce the risks of people becoming confused when walking.
● People's rooms were personalised with things that mattered to them including photos, paintings and ornaments. People told us they were encouraged to personalise their rooms. We observed 1 person had fresh flowers on their table. The person told us their room "Feels like my own, like at home really." One relative told us, "When he first went there, everything we asked for in the room was done."

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

● Some people told us, they had not always been supported by staff with their oral care when needed whilst others said they were supported. We noted one person's toothbrush was still in its packaging. Oral health care plans were not always detailed with guidance for staff on how best to support people. We fed this back to the provider who told us they would review this.

● People and relatives fed back positively about the health care support they received. One person told us, "I see the doctor when I need to, staff seem to be able to arrange this for me. The nurses here take good care of my wounds." A relative told us, "I'd noticed one day [loved one] was struggling a bit with breathing. They popped in to check his skin because that was a bit sore, but they got the doctor in, and they gave him great care."

● People's care records showed relevant health and social care professionals were involved with people's care. Records showed involvement of the dietician, physiotherapist, GP, specialist hospitals, Parkinson nurse, epilepsy nurse, dietician and the Speech and Language Therapist (SaLT). Care records showed that people had regular annual eye checks and regular involvement of the chiropodist. Staff followed the guidance provided the health care professionals.

● Care staff worked well with the nurses and external health care professionals to provide the most effective care. One member of staff told us, "It is brilliant, we have close discussions with nurses and can approach them." When health care professionals visited staff worked closely with them. One health care professional told us staff always had the available clinical information for them to review.

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 last inspection in June 2021, we rated this key question requires improvement. The rating for this key question has remained 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

At our inspection in June 2021, we found people were not always treated with dignity and respect and were not 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. At this inspection we found sufficient improvements had not been made and the provider remained in breach of regulation 10.

● We found instances during the inspection where people were not always treated with dignity and respect. There were nurses visiting people's rooms in the morning to do a handover. One person asked the nurse going off duty who the other member of staff was. The nurse responded, "This is my colleague, we are doing handover" but then continued to talk about the person to the nurse coming on duty which was not respectful. We also heard the nurse not respecting people's privacy by talking about their needs whilst stood in the corridor which could be heard by anyone nearby. The registered manager told us they had trialled a new style of handover but agreed they would revert to undertaking a handover with all staff in a more private area.
● People told us they did not always have the option to have a bath or a shower each day and we confirmed this from the records. We observed people's hair did not always look clean and tidy. One person fed back they had not had the opportunity to have their hair washed and this was important to them. They told us, "I had my hair washed maybe once since I got here." Another person told us, "Staff help me to wash, but I have only had one bath since I have been here. I was onto the carer about this this morning, and I think they said I can have one at the weekend, it would be good to have one." We raised this with the provider who has arranged for this person to have their hair washed.
● We observed undignified language being used to discuss people including in people's care notes. During the handover we heard a member of staff making "Can be moody" comment out loud. In care notes we saw undignified language about people including, "Obsessed with people giving me attention."
● One person had expressed anxiety that another person was using their wheelchair. Staff did not respond well to this and did not offer appropriate reassurance. We noted the person's wheelchair was also covered in stickers with a previous resident's name on it. Staff had not considered this was undignified for the person.
● We observed 2 instances during breakfast and lunch where staff stood next to a person to assist them to eat rather than sit down next to them which would have been more dignified.

As people were not always treated with dignity and respect and were not always given choices around their

delivery of care this was a continued breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● People were positive about the caring nature of staff. Comments included, "All the staff are very supportive and considerate" and "I can't say bad word about [staff], they are all nice."
● Relatives also fed back positively about the caring nature of staff. Comments included. "The majority are really good and caring" and "They are caring. They are so chatty. The staff are lovely. [Member of staff] is very patient and nice with [loved on]."
● We observed staff taking time to get to know people, listening and understanding their wants, needs and wishes. One person mistook an inspector for their relative who they were missing. A member of staff reassured the person by calmy explaining who the inspector was but also validated how the person must be feeling.
● Another person was anxious and was saying they wanted to go home. A member of staff went and got a phone for them to speak to their relative which the member of staff knew would calm the person. The member of staff told us, "I really love caring for people, it is my pleasure."
● People were encouraged with their independence. One person told us, "I like to do as much as I can for myself which staff seem to understand and respect." A relative told us, "Staff continue to encourage [family member] to do as much as possible." A member of staff told us, "I try my best to encourage people as much as possible, even just holding their own toast; to wash some parts of themselves."
● Staff had organised for a person to celebrate their special wedding anniversary which the relative said meant a lot to them.

Supporting people to express their views and be involved in making decisions about their care
● In other areas people and their relatives were actively encouraged to be involved in decisions around their care. They were able to make choices about when to get up in the morning, what to wear and activities they would like to participate in.
● Relatives told us their loved ones were involved in day-to-day decision making. Comments included, "Staff make sure they explain and ask [loved one] for everything; they always tell her what they are going to do before they do it" and "Staff respect her choices and ask her if she needs help with something rather than doing it for her".

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 June 2021, we rated this key question requires improvement. The rating for this key question has remained 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. For example, where people told us about the jobs they used to do and what was important to them, this was not included in the care plans. Having this information helps staff develop relationships with people they were supporting. After the inspection the provider sent us 'This is me' documents that contained some information on people life histories.
- 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, we noted 1 person was resistant to wearing their continence aid and we heard this was discussed during the handover. However, there was no reference to this in the care plan and no guidance for staff.
- Another person's care plan stated they required hearing aids but declined to wear them. However, another part of the care plan stated the person had good hearing. Staff may not support the person appropriately because of contradicting information. The registered manager told us, "I have concerns about care plans, so I devise a tracker with all the residents and then to do a deep dive in."
- Staff's daily notes lacked personalisation and were brief and repetitive. There was little variation between entries, and some entries are more detailed than others. One person's 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.
- Care for people at the end of their life was not always provided in a meaningful way. One person was receiving end of the life and no actions had been taken by the registered manager to ensure a staff member would be with them during their last hours. The registered manager told us, "The expectation (is) that someone is in the room with them. That's very sad to hear. I remind them [staff] it's essential." This was also referenced in the service's End of Life Policy where it stated a member of staff should be with the person in the absence of family.
- End of life care was not being planned around people's wishes. There was insufficient evidence that discussions took place with people around their wishes nearing the end of their life. One relative told us, "[Staff have] not explored about what good end of life care would look like. It's important our wishes and [loves one] wishes are respected." Another told us, "We haven't spoken about that [end of life care]."

Care and treatment was not always planned that met people's individual and most current needs. This is a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were relatives who fed back positively about the care their loved ones received at the end of the lives. One relative told us, "The staff were outstanding they were so kind and good with him." Another told us, "I felt they were very compassionate. Right at the end he saw the doctor a lot and she came to know him."

Improving care quality in response to complaints or concerns

At the inspection in June 2021, we found complaints and concerns were not always investigated and appropriate action had not been taken. This was a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection this had not improved sufficiently, and the provider remained in breach of regulation 16.

● People were not always confident their concerns would be listened to, and actions taken. Comments included, "The deputy manager comes in and listens, but nothing got changed" and "My bed linen, they don't straighten out the bottom sheet. The creases dig into you. I have raised it twice, but it still keeps happening."
● Another person said they had raised concerns about the food options available to them and the time it took for their call bell to be responded. Both, the person told us, had not been resolved.
● There had only been 3 recorded complaints this year. However, on reviewing the responses from the registered manager there was a heavy reliance on staff's account of the concern rather than what was observed by the complainant. One relative told us of the complaint response, "I didn't respond again further. You get to end of your tether. I wasn't happy with the response."

As complaints and concerns were not always investigated, and appropriate action taken this was a continued 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.

● People's care plans guided staff how best to communicate with people. This included whether they required their glasses for reading or whether a person's first language was not English.
● One person told us, "We manage [with communication despite language barrier]. I can tell them what I want, and they try to understand, I show them, we manage very well. It is not a problem." We heard staff using simple words in the person's native language.
● Staff understood how best to communicate with people. One member of staff told us about a person's needs, "Get close, speak clearly and slowly, I usually kneel in front of him to get on his level so staff hear better, and he can understand more easily." We saw this in practice on the day.

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
At the inspection in June 2021, we found there were not enough meaningful activities for people. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this we found this had improved and the provider was no longer in breach of regulation 9 relating to activities.

● People and relatives were positive about the range of activities on offer at the service. Comments included, "I think there is plenty going on here. I go up to the top floor to play games", "[Relative] chooses to join in or not with activities, depending on the mood. I know staff always ask her to join in" and "There is enough going on and she has improved since she's been there. She now socialises more than she did."
● We were shown examples of instances since the last inspection where staff had arranged for personalised activities for groups of people which were specific to their preferences. This included trips out locally, eating out and events in the home including a BBQ where families were also invited. One person told us, "It was lovely, and many people came, and all had fun."

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 requires improvement. 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

● The leadership at the service remained poor and we found new and continued breaches at this inspection. We found the registered manager's and provider's oversight of the quality of care was not effective.
● People and relatives were not always confident in the leadership at the service. Comments from them included, "You can't talk to the [registered] manager. Whenever I ask, she is in a meeting or somewhere else", "She [registered manager] comes round on occasion, it wouldn't hurt to see her more. There are 1 or 2 things I'd like to say to her" and "[Registered manager] like a law unto herself. She says her door is always open, but the only problem is she is never behind it. You can never actually get to her."
● Prior to our inspection the new process of handover had been trialled to only include the senior staff on each floor. However, we found this was not inclusive and impacted care staff who were not being provided with important information on people. A member of staff had not been told about a person's passing away and had entered their room to deliver their care. A member of staff told us, "Staff work across floors and handover used to be for all staff to discuss all residents, difficult to keep up to date if things change." The provider has told us they have now changed the handover back to include all staff.
● When we fed back areas for improvement on the day of the inspection, staff were at times reprimanded in front of us. This did not support a positive culture. One member of staff told, "It would be better if staff that need to be corrected it is not done in front of other staff and sometimes families." This meant the management at the service were not clear about their roles and responsibilities and failed to prevent a blame culture.
● Internal quality assurance systems designed to review the service's performance and the safety and quality of care were not operating effectively. Numerous audits undertaken by staff at all levels within the organisation had not always identified or prevented poor practices occurring or continuing at the service.
● For example, we found an assisted communal bathroom was dirty and large amounts of boxes and painting/redecorating equipment had been left. The door had been left unlocked and the bathroom was accessible to people. The management team was aware of this but took no steps to address this until we raised it.
● The audits taking place had failed to identify some the shortfalls we found during the inspection. This included the lack planning around end of life care, adhering to the principles of MCA, deployment of staff, meal choices and the management of oral health care.
● People's care records were not always accurate and up to date. For example, we found gaps on the

majority of the topical cream charts we reviewed, and it was not clear whether people had received their creams on those days. One person was due to attend a health appointment however there was no record of how this appointment went. A member of staff told us the person had refused to attend the appointment on that day however the care plan had not been updated to reflect this.

The failure to ensure quality assurance and governance systems were effective, and records related to the provision of support for people were adequately maintained is a breach of Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● Since the inspection, the provider has increased the management resources to support staff at the service.

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

● The registered manager was not always open and transparent with us during the inspection. For example, we had identified concerns with the excess of dirty washing in the laundry room. The registered manager told us they had organised for this to be collected by their sister home prior to the inspection. However, the regional manager told us this was not the case and they themselves had organised this earlier that day.

● The registered manager had not always ensured they had shared information with funding authorities regarding people being harmed to ensure there was an adequately informed review, investigation and actions agreed to help avoid or prevent these issues happening again. One external professional told us, "It can be hit and miss with how quickly they (managers) provide the information required and there are times I have to chase up."

● Although the registered manager told us they understood their responsibilities around Duty of Candour this was not always put in practice. We noted from incident reports that relatives had not always been contacted when an incident or accident occurred with their loved ones

● Systems were not in place to identify those incidents that needed reporting. The registered manager had not informed the CQC of all significant events including incidents and safeguarding concerns. This included when people sustained significant skin tears or unexplained bruising.

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.

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. Although residents' meetings were taking place the only item on the agendas was what activities they wanted to take place. There were no discussions about food or any other aspects of the care delivery for them to feedback on.

● Whilst relatives meetings took place, relatives did not always feel that changes took place when they raised things. At the last meeting in May 2023, it was suggested that new chairs were required for the nursing floor however this had still not been actioned. One relative said, "We are asked what we would like better but can't think that anything is done."

● People were last sent a survey in 2022. Whilst there were improvements made to activities as a result of people's feedback there were still no action to address the menu choices which was a continued concern at this inspection.

● Relatives were also sent a survey and again whilst some areas had improved because of the feedback other areas had not been addressed. This included the lack of adequate personal hygiene provided to one

person and concerns about their relatives needs being met in a timely manner. We found concerns in both areas at this inspection.

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

● Staff fed back the meetings that took place were helpful. One told us, "We all help each other out. We have a staff meeting every month and this is where I can bring anything I want to discuss. It helps to be able to discuss this in the meeting and reach a solution, for example about staffing."
● Some staff were complimentary of the leadership and felt supported. Comments included, "The manager keeps us informed. She comes [to the floors] and we see her, she is approachable", "The manager is very supportive to me, for all the things I needed" and "Management support us with everything, we can talk with them. The deputy is very lovely, nurses as well."

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 not always planned that met people's individual and most current needs.

The enforcement action we took:

We have imposed a condition to 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 failed to ensure people were always treated with dignity and respect.

The enforcement action we took:

We have imposed a condition to the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The provider failed to ensure the principles of the Mental Capacity Act 2005 were consistently followed .

The enforcement action we took:

We have 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 medicines and risks associated with people's care was always managed in a safe way.

The enforcement action we took:

We have imposed a condition to the providers registration.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider failed to ensure complaints and concerns were not always investigated, and appropriate action taken.

The enforcement action we took:

We have imposed a condition to the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure quality assurance and governance systems were effective, and records related to the provision of support for people were adequately maintained. They failed to ensure the service performance was evaluated and improved and the service worked in partnership effectively with other agencies.

The enforcement action we took:

We have imposed a condition to the providers registration.

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

The enforcement action we took:

We have imposed a condition to the providers registration.