Purelake (Chase) Limited

The Chase

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
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
The Chase is a residential care home providing personal care for 31 older people and people living with dementia. At the time of the inspection 28 people were living in the service. Most of the people lived with dementia and had special communication needs.

People's experience of using this service and what we found
People and their loved ones told us they felt safe and well cared for at the service. However, we found people were not safe and well cared for. People lived in an environment which was unsafe and unhygienic. Areas of the service had unpleasant odours and flooring was a trip hazard. Systems to manage infection control were not effective.

Risks to people were not always assessed and managed in a way which ensured people's safety. Actions had not been taken to minimise risks and staff were not always aware of plans to keep people safe. This put people at risk of injury or their health deteriorating. There had been some improvements in medicines management, but some medicines continued to be administered in an unsafe way putting people's health at risk.

People's health care needs were not well managed. Communication systems were ineffective in ensuring staff understood people's health needs. There was a risk that people would not receive the care they needed. People were not always supported to have their food and drink in ways they preferred or met their needs.

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 fully supported to maintain their dignity. They were left in dirty or torn clothing and were not assisted to wash after meals. People went for long periods of time without meaningful interaction with staff. People's preferences were not always known or followed and care plans did not contain up to date information. People had not been fully supported to plan their care they preferred at the end of their life.

Although there were arrangements to resolve complaints a recent enquiry had not been thoroughly investigated and quickly resolved. Audits were ineffective and did not identify the shortfalls found at this inspection. The provider had failed to take action when concerns were raised to them. Staff were recruited safely but did not have the training and support they required to carry out their role. Staff told us there was low morale and they did not feel able to raise concerns or make suggestions. There were shortfalls in the systems and processes to learn from incidents or accidents to minimise the risk of recurrence.

Information was not available to people in accessible formats. Staff worked with other professionals to meet

people's needs. However, a lack of knowledge about people's needs impacted on staff knowing when to seek support. People attended residents' meetings and had been invited to complete quality surveys.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 22 November 2018). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection, enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
The inspection was prompted in part by notification of a specific incident. Following which a person using the service died. This incident is subject to a criminal investigation. As a result, this inspection did not examine the circumstances of the incident.

The information CQC received about the incident indicated concerns about the management of choking. This inspection examined those risks.

We have found evidence that the provider needs to make improvements.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We have identified new and continued breaches in relation to safe care and treatment, need to consent, dignity and respect, staff training, the environment and good governance.

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

The 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 of their registration.

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

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 effective.

Details are in our effective findings below.

Inadequate

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

The Chase

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by three inspectors. Two inspectors assessed how the service was meeting each of the five key questions we ask. The third inspector assessed how the service had responded to a specific incident as a result of which a person died. There was also an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
The Chase is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
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 the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

Due to technical reasons, the provider was not able to complete a Provider Information Return. This is information we require providers to send us to give us some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made judgements in this report.

During the inspection
We spoke with 16 people who used the service and five relatives about their experience of the care provided. We spoke with seven members of staff including the nominated individual, registered manager, assistant manager, senior care workers, care workers and the chef. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke to a visiting health and social care professional.

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

We reviewed a range of records. This included eight people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service.

After the inspection
We requested additional documents from the registered manager to validate evidence found. The registered manager also sent additional evidence they wished us to consider.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Using medicines safely

At our last inspection the provider had failed to mitigate known risks to people, protect them from avoidable harm and manage medicines safely. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

● People were at risk of harm because staff did not know what actions were needed to be taken to keep them safe. Risks to people had been assessed, however guidance for staff did not give them all the information they needed to manage risks. Four care staff were unaware of a food a speech and language therapist had identified as putting a person at increased risk of choking. This increased the chance of the person being offered food it was not safe for them to eat it.
● People were not protected from the risk of falling and sustaining an injury. Staff did not follow people's care plans to minimise the impact of any falls. For example, one person's risk assessment stated they should have a 'crash mat' next to their bed. The registered manager said this was necessary because the person was at risk of falling when getting out of bed and benefited from there being a soft surface to reduce the risk of injury if they fell. However, the crash mat was not in use and had been replaced by an electronic mat that alerted staff when the person was getting out of bed. The alert mat was not switched on and did not provide a soft surface. This further increased the risk the person would sustain an injury if they fell.
● Four people were not fully protected from the risk of losing weight. The registered manager said that people needed to have their weights regularly taken and analysed to ensure their body weight remained in a safe range. However, four people's weights had not been analysed in the right way. This reduced the service's ability to identify if medical advice needed to be obtained to help a person stay well. This was reflected in an example when advice had not promptly been sought after a person had lost weight quickly.
● Action had not been taken to protect people in an emergency. A deputy manager said fire drills needed to be completed at least every six months. This was so staff knew what action to take to keep people safe in the event of a fire. However, records showed and staff confirmed that fire drills had not been completed regularly. We saw records of a drill in July 2018, after the inspection we received details of a further set of drills in July 2019. We asked seven staff about the action they would take in the event of a fire. Four staff including a senior member of staff did not fully know the correct procedure to follow.
● There were personal evacuation plans describing the support people need to evacuate in an emergency. A deputy manager said the plans needed to be reviewed at least once a year to make sure they remained accurate. However, we found the plans had not been updated since June 2018. This shortfall increased the risk staff and fire officers would not have the accurate information about the support people needed to stay

safe in the event of a fire.
● At our last inspection people had not consistently been assisted to manage medicines safely. Some liquid medicines had not been date marked when they had first been opened. This increased the risk that the medicines would still be used after they had passed their 'use-by' date. A record had not been completed when some creams had been dispensed and so it was not clear if they had been used in the correct way. Some creams had not been stored securely increasing the risk that they would be used by another person living in the service for whom they had not been prescribed. The stock of two people's medicines held in the service was not correct. This indicated the people concerned may not have been assisted to use their medicines as intended by their doctors.
● At this inspection all the above shortfalls had been addressed. During the inspection medicines were dispensed in the right way. Staff checked they were giving the right medicine, to the right person at the right time. However, there were additional concerns that people's medicines were not always administered safely. One person's medicines were given covertly, (without their knowledge). This involved the medicines being ground up and placed in their food. Although staff told us they had agreed this with the GP there were no records to support this. Covert administration had not been discussed with a pharmacist to ensure the medicines used could be crushed safely. There is a risk that medicines may not work in the way they should or could irritate the person's stomach.

The provider and registered manager had failed to assess and mitigate risks to people to protect them from avoidable harm and medicines were not always managed safely. This is a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● People were not protected from the risk of infection. Although there were domestic staff who followed a cleaning schedule in practice this arrangement was not effective. Various areas of the service had a strong odour of urine including bedrooms, bathrooms and some hallways. Equipment around the service, such as light pull cords and paper towel dispensers were discoloured and dirty. Many had cracks in them and so could not be cleaned to a hygienic standard. People used plates and cups which were chipped and as a result could not be thoroughly cleaned. This raised the risk of infection transferring from one person to another.
● Bedrooms were not properly cleaned when people left the service. A family member had complained their loved one had lost a valuable item when they left the service. During our inspection we viewed the empty room. On moving a piece of furniture, we found the item laying underneath. Had the room been cleaned thoroughly by staff, the item would have been found and could have been returned. The bedroom was not clean. The carpet was stained, dusty and littered with sweet papers. The bedside cabinet and wardrobe had dirty marks on their surfaces as did the main door and door handle.
● Effective systems were not in place to ensure people's laundry was washed promptly. On the day of the inspection the laundry room contained 13 bags of used clothing or bedding and two waist-high laundry containers full of used items. The laundry room was dirty and the floor was stained. The door of the washing machine was discoloured with dried-on washing powder and lime-scale. Staff told us the laundry did not have enough capacity to promptly wash and dry people's clothes. The provider said the service did not have enough staff to run the laundry in the right way. This resulted in occasions when garments and bedding used by people who experienced problems with their continence were stored with other less soiled items for long periods of time in a hot setting. The arrangement increased the risk of items becoming too soiled to enable them to be cleaned effectively. The build-up of laundry also increased the chance of people not having a full wardrobe of clean clothes from which to choose.

The provider and registered manager had failed to take the necessary measures to minimise the risk of

infection. This is a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

● Effective action had not been taken to learn lessons when things had gone wrong. Accidents and incidents had been reviewed by the registered manager. However, reviews did not always record actions taken to prevent them occurring again or identify any patterns and trends.

● People's care plans were not always updated following accidents. The registered manager told us a person had experienced a number of falls and was at risk of falling again. This was due to a general decline in the person's mobility. The accident form stated they should be given one to one support to move around the service to minimise the risk of them falling again. This information was not recorded in the person's care plan and some staff were not aware of the need to provide this assistance. During our inspection we saw two occasions when the person was moving around the service without support. They were very unsteady and at risk of falling. Although staff were present they did not offer the person assistance until we asked them to do so.

● Following a recent incident of choking the registered manager had quickly called to the service to establish what had gone wrong and what needed to be done to keep other people safe who were at risk of choking. However, this had not resulted in suitable arrangements being put in place so all care staff knew the actions to take to reduce the risk. A person whose care plan stated was at risk of choking when eating and so who needed to be monitored was left alone with their food for 15 minutes after their lunch was served on the second day of our inspection visit. Another person's care plan also stated they were at risk of choking and needed to be closely monitored when eating. This was because they had a serious medical condition that increased the risk of bleeding in their throat. None of the staff including the registered manager knew about this matter. No arrangements had been made for the person to quickly receive medical attention should they begin choking and urgently need assistance.

The provider and registered manager had failed to ensure that incidents or accidents were thoroughly investigated and monitor to ensure measures are in place to prevent reoccurrence. This is a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● People told us they felt safe at the service and that staff took good care of them. However, we found people were not protected from the risk of harm and abuse.

● Staff told us about the different types of abuse they may encounter and the actions they would take if they had any concerns. This included external agencies to whom they could whistle-blow.

Staffing and recruitment

At our last inspection the provider had failed to operate robust recruitment processes. This was a breach of regulation 19 (Fit and Proper Persons) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 19.

● Staff were recruited safely. Checks were made including references from previous employers and criminal records checks.

● At our last inspection we recommended the provider review their process for covering shifts in the case of staff absence. The provider had made improvements.

● There were enough staff on duty to keep people safe and sickness and annual leave were now covered by

staff within the service. On rare occasions agency staff were used to ensure there were enough staff to support people.

Inadequate

Is the service effective?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience
At our last inspection the provider had failed to ensure staff were trained and competent. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● Staff did not have all the skills and knowledge they needed to meet people's needs. Staff had undertaken training courses since the last inspection and competency checks were being completed. This had not been effective and we found gaps in staff's knowledge and understanding in relation to managing risks and people's support needs. For example, staff had completed training around supporting people to maintain their skin healthy. However, none of the staff we spoke to could tell us how to ensure people's inflatable pressure relieving equipment was working correctly. If these items of equipment are not inflated to the correct level there is a risk people will not be fully protected from developing sore skin. We checked the pressure to which a person's inflatable mattress had been set. The member of staff with us did not know the correct pressure to which the mattress should have been set.
● Several people at the service were living with mental health conditions. Staff had not completed any training about supporting people with mental health conditions. There was a risk people would not receive the support they needed to remain well and changes in their mental health may not be identified promptly. An example was a person who became distressed during lunchtime. They were concerned that another person was sitting in their place at one of the dining tables. Staff were not sure how best to reassure the person and adopted different and contradictory approaches. One member of staff advised the person that people did not have personal places in the dining room. This did not reassure the person and so a second member of staff suggested that the two people concerned change places. This resulted in a disagreement between the people concerned that was only resolved with a third member of staff suggested that the original person dine in their bedroom. The person was known to sometimes prefer to dine in private and they were happy to be supported to go to their bedroom.
● Staff had completed training in relation to infection control. However, some staff including the registered manager and nominated individual did not recognise the multiple infection control risks we found around the service. This was because they did not have the skills and knowledge necessary to identify shortfalls in the promotion of good standards of hygiene.

The provider and registered manager had failed to ensure staff had the training required and were competent to carry out their role. This is a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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

● At the last two inspections of the service we reported that some of the carpets at the service were in a poor condition. Following the last inspection, the provider told us this would be replaced. They had not completed this work and did not have plans in place to ensure it happened. The provider told us they were waiting for building work to be completed in October 2019 before replacing further carpets. The carpets in communal areas and in some bedrooms were heavily stained. In some places the carpets were so dirty they were black in colour and stuck to the inspectors' shoes. Some carpets also had an unpleasant odour. In some places tears in carpet seams had been crudely covered with tape which had lifted causing a trip hazard to people and staff.

● Other areas of the service were also in disrepair. A window in a communal area had a broken pane of glass covered with tape. After the inspection visit the provider told us the defect had been scheduled for repair. Another window had a power cable running through it to supply electricity to an external shed used by building contractors working on an extension to the service. The arrangement that was in place during working hours prevented the window closing and caused a draught.

● Bathroom floors were stained with dirt, sealant was missing around the base of toilets and ceramic tiles were missing. This increased the risk of infections spreading as these defects meant the areas in question could not be cleaned to a hygienic standard. After the inspection visit the provider told us the tiles had been replaced.

● Most areas of the service were in need of redecoration with chips in paint and dirty woodwork in bedrooms and communal areas. None of the issues we found were recorded in the maintenance records as requiring attention. We raised these shortfalls with the nominated individual. They said, "We need to do a lot of work to get the place up to standard. It's not the homely setting we want it to be at all."

The provider and registered manager had failed to ensure the premises and equipment were clean and properly maintained. This is a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Ensuring consent to care and treatment in line with law and guidance

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

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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● Staff were not following the principles of MCA. Capacity assessments had not always been completed. Assessments which were in place covered general agreements to care rather than specific decisions. Assessments had not been reviewed or updated. Some people had fluctuating capacity as a result of living with dementia or mental health conditions. This was not recorded in their care plans or been taken into account when completing assessments.

● When people were assessed as lacking capacity discussions had not been held to ensure decisions made

were in their best interests. For example, in relation to restrictions such as the use of bed rails or treatments including covert administration of medicines. This increased the risk that people would be provided with care that was not the least restrictive possible and did not fully respect their legal rights.
● DoLS authorisations had been applied for and updated as required.

The provider and registered manager had failed to ensure people's capacity was assessed in line with the Mental Capacity Act (2005). This is a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● The registered manager said that there was a policy and procedure for staff to follow when supporting people to meet their healthcare needs. This included offering to call a person's GP when needed.
● We found appropriate action had not always been taken to support people to stay well. Some people had received injures as a result of falling. The records we saw did not show action had been taken to contact health professionals and ensure that people had treatment if required. After the inspection visit the provider assured us advice was sought from healthcare professionals to reduce the risk of falls occurring.
● Another person was recorded as having a (pressure) blister on their skin and unexplained bruising. The only action recorded was to 'inform the senior carer'. No photograph or record of the size of the blister had been kept to support staff to monitor any deterioration or improvement. There was no record that the GP or district nurse had been contacted for support.
● Some people lived with complex mental health conditions. Staff had not been provided with comprehensive information about how the conditions affected the people or signs their mental health was declining. Staff including the registered manager did not have a detailed understanding of the people's special needs for assistance. This increased the risk the people concerned would not be quickly referred to mental health professionals when they were becoming unwell so that changes could be made to the treatment they received.

The provider and registered manager failed to ensure that people's health care was managed in a way which ensured people were safe. This is a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● People were not consistently offered food and drinks in the way they needed or met their needs. People had a choice of meals and staff used photographs of the meals on offer to support them to choose what they preferred.
● When people required their food prepared differently such as in a soft texture or pureed this was done. On the day of our inspection we observed food was prepared as recommended by their health care professionals. However, it was not presented in an appetising way. One person's meal was pureed all together creating an unappetising brown meal. Good practice is to puree each ingredient separately so people can taste the different flavours.
● People were encouraged to stay hydrated and had access to cold drinks in communal areas and their rooms. However, one person had their drinks removed from their room due to them attempting to water artificial plants with it. No attempt had been made to find an alternative way for the person to access drinks in their room.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● During the inspection visit we found there were shortfalls in the assessments completed by the registered

manager of people's needs before they moved into the service. On some occasions the assessments had relied too heavily on information from other agencies or service providers. This increased the risk of people moving into the service who required more assistance than could be provided. After the inspection visit the provider told us comprehensive assessments were completed to ensure new people's needs for care could reliably be met.

● Some assessments were not available for us to see because they had been archived, in line with the providers policy. The assessments we did see did not fully take into account people's protected characteristics under the Equality Act (2010). This had resulted in shortfalls in the provision made to respect people's preferences. An example of this was the gender of staff who provided a person's close personal care. Some staff did not know which people had expressed a preference about this matter increasing the likelihood that their preferences were not respected. A woman said, "I don't want a male carer to help me in the bathroom and sometimes I have to remind the staff about this which I shouldn't have to do." They did tell us that male carers found a female member of staff when reminded. After the inspection visit the provider told us information about people's choices in relation to this was included in care plans and was known to care staff.

● Assessments did not always include the use of recognised tools to assess people's level of support need and risk. An example of this was nationally recognised tools not being used to help care staff appropriately support people who were experiencing difficulties maintaining a safe body-weight.

The provider and registered manager had failed to ensure people's needs were fully assessed and supported in a way which met their needs and preferences. This is a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has now remained the same, requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence

At our last inspection the provider had failed to ensure that people's dignity was respected. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 10.

● Some people who needed support to maintain their personal appearance had not been assisted to wear clean clothes. Two hours after lunch we saw some people who lived with dementia wearing clothing with food stains on them. A person who also lived with dementia had not been assisted to clean their face after they had spilt food on their chin. Other people's hands were not clean and some of them also had fingernails discoloured with dirt.
● At the last inspection a person was left without a shave despite requesting one. At this inspection people were again left unshaven. One person told us they would like a shave and had asked for one, but staff had not supported them with this by half past four in the afternoon when inspectors left the service.
● One person's assessment and care plan stated that their personal hygiene was very important to them and they wished to have a daily shower. After a number of months their care plan had been altered, informing staff to only offer them a shower once a week. The registered manager did not know about this change to the care provided to the person. They assured us they would consult with the person and ensure they were supported to have a shower as frequently as they wished.
● Some people were seen to be wearing clothes that were torn. Some people were not wearing either socks or slippers.

Ensuring people are well treated and supported; respecting equality and diversity
● People told us staff knew them well and were caring and kind. One person said, "The staff can't do enough for me." However, people were left for long periods of time without meaningful interaction. Our observations showed that for most of the time people were passive. Many sat in the lounge area without anything to occupy their time or napping.
● On the first day of the inspection a person sat in the lounge from 10:00am until after lunch. Although during that time staff periodically passed through the room and said 'hello' to the person, no attempt was made to engage them in any activity or conversation. The person spent long periods of time in a withdrawn state and did not enjoy any meaningful contact with their setting.

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

● People had not been fully supported to express their views about things that were important to them. On some occasions staff provided care for people in a task-centred way. An example of this was a member of staff who lifted a person's arm to help them to stand so they could walk from the lounge to the dining room. The member of staff did not speak to the person who was startled and who indicated they did not want to leave the lounge.

● People had not been fully supported to regain and develop their independence. Care plans did not show people had been invited to set and work towards achieving personal goals. Most staff did not appreciate the importance of promoting people's independence. This was reflected in staff doing tasks for people rather than giving people the time and space to do things in their own way. An example of this was a member of staff who took the remote control a person had been using to change channels on their television. Before this, the person had been working their way through various channels to find a programme they wanted to watch. The member of staff chose the wrong channel. After they left the person took back the remote control and changed the channel to show the programme they had chosen.

● Most people had relatives and friends who could help them make decisions about the care they received. However, some people only had infrequent visitors. During the inspection visit a senior member of staff told us the service had not developed links with lay advocacy services. Lay advocates are independent of the service and can help people weigh up information, make decisions and say how they want things done. This increased the risk that people would not be fully supported to make and voice decisions about how they wanted to receive care. After the inspection visit the provider told us advocates had been accessed to help people express their views and take decisions.

● Private information was not always kept confidential. Although staff had received training about the importance of maintaining confidentiality this was not always followed. There were examples of care staff discussing people's care needs in ways likely to be overheard by other people living in the service. There were other examples of records that contained sensitive personal information being left unsecured.

The provider and registered manager had failed to ensure people were supported in a way which respected their dignity. This is a continuing breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now remained the same, 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

- People's care had not been consistently planned with them and their relatives to meet their needs and preferences. Detailed guidance had not been provided to staff about the support they should offer people. For example, when people were upset or anxious there was limited or no guidance for staff about how to reassure them. Some plans had more detailed information than others. However, key parts of some care plans were based on historic information obtained from staff working in other services. This increased the risk the care plans in question were no longer appropriate or relevant.
- People's care plans were not always up to date and some contained contradictory information. For example, one person's care plan contained two different sets of guidance lines from a speech and language therapist. The documents contradicted each other and there was a risk staff would follow the wrong directions which placed the person at risk of choking.
- Staff were often unaware of guidance in people's care plans or gave us contradictory information about how people should be supported. For example, one person had sweets brought in by a loved one and could be at risk of choking by eating too quickly. Three staff gave us three different answers about the level and kind of support the person needed.

End of life care and support

- People had not been fully supported to share their end of life preferences with staff and there was a risk they would not receive care and treatment in the way they preferred at the end of their life. Some people did not have end of life care plans.
- At the time of our inspection visit, no one needed to receive end of life care. The registered manager said they would only prepare an end of life care plan as and when a person needed palliative care. People and their loved ones should be supported to share their preferences and wishes before they become unwell. This is necessary to ensure people's choices are well known and so any necessary arrangements can be put in place. These include where people wish to be cared for, who they would like to be with them and any spiritual needs. After the inspection visit the provider said people's relatives had been consulted about preparing end of life care plans for their family members but that some of them had been reluctant to engage with this difficult subject.
- Some people did have information from their GP about their wishes in relation to medical interventions or documents stating they did not want to be resuscitated.

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 our last inspection we recommended that the provider source expert advice and training to help develop appropriate activities for people living with dementia and cognitive memory loss. The provider had not made improvements.

● People were not supported to take part in activities and day to day tasks which they enjoyed. The registered manager told us they had looked on line for some ideas for activities and some sensory activities had recently been introduced. However, there had been limited changes to the activities people were offered. The majority of activities on offer did not take into account the needs of people living with dementia.
● There was a dedicated activity member of staff seven days a week. During the inspection we saw some people take part in a ball game and a quiz. However, for long periods of time people were not engaged and people who remained in their rooms were not supported to take part in activities of their choice. After the inspection visit the provider sent us a list of social activities they said people could choose to undertake. These included arts and crafts, baking and trips out.
● People could have visitors at any time and relatives told us they were always made welcome.

The provider and registered manager had failed to plan people's care with them to ensure it met their needs and preferences. They had failed to ensure that activities were suitable for people. This is a breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
● The registered provider had a policy and procedure for managing complaints. It said the receipt of complaints needed to be acknowledged and the content of complaints needed to be fully recorded. The documents also said all complaints needed to be fully investigated and resolved to the complainant's satisfaction. The nominated individual said that each of these stages was 'essential' so mistakes could be put right and lessons learned for the future.
● The registered manager said the service had not received any complaints since the last inspection. A deputy manager said an enquiry had been received from a person's relative about a valuable item of jewellery that had been mislaid and could not be found. The registered manager and nominated individual were not able to describe the actions they had taken to resolve the matter. No one had contacted the relative to explain the item of jewellery remained missing. Also, the relative had not even been contacted by the second day of our inspection visit even though we found and handed the item of jewellery to a deputy manager on the first day of our inspection visit.'

The provider and registered manager had failed to operate an effective system for recording and handling complaints. This was a breach of regulation 16 (Receiving and Acting On Complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some The registered manager said the service had not received any complaints since the last inspection. A deputy manager said an enquiry had been received from a person's relative about a valuable item of jewellery that had been mislaid and could not be found. The registered manager and nominated individual were not able to describe the actions they had taken to resolve the matter. No one had contacted the relative to explain the item of jewellery remained missing. Also, the

relative had not even been contacted by the second day of our inspection visit even though we found and handed the item of jewellery to a deputy manager on the first day of our inspection visit.
circumstances to their carers.

- People had not been supported to access all the information about them and the service they needed. Some care plans had pictures added to them to highlight the area of care described, however the language used in writing the care plan was not accessible to people and no alternative formats were available.
- Complaints procedures and other information people may need about the service was not available in an accessible format.

We recommend the provider seek advice from a reputable source in relation to making information accessible to people.

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated 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.

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

At our last inspection the provider had failed to ensure systems to monitor the quality of the service were affective and risks to people were mitigated. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● Effective systems were not in operation to assess and improve the quality of the service and people continued to receive an unsafe service. A variety of audits had been completed to monitor the running of service but these had not identified and resolved the multiple and serious shortfalls we found. An example of this was infection control audits not highlighting concerns around the cleanliness of the service. Another example was care plan and risk assessment audits not identifying contradictions in information or gaps in guidance for staff.
● Health and safety walk arounds completed by the registered manager had not identified environmental issues such as the broken window and missing tiles in bathrooms.
● Notifications of specific events and incidents had been submitted to CQC. However, these did not always provide a suitably complete account of what had occurred and the actions taken to keep people safe. This increased the risk that we would be misinformed about the adequacy of the steps taken to safeguard people from the risk of harm.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Although residents' meetings had been held these were not well attended. After the inspection visit the provider told us people had also been invited to complete quality assurance surveys.
● The provider and registered manager had not developed a positive and supportive culture at the service. There was a lack of openness and transparency. Staff told us they were unaware of the outcomes of audits and were not informed when changes were made to people's care and treatment. After the inspection visit the provider told us measures were in place to promote communication within the staff team. These included communication books to pass on information between senior staff and handover meetings between shifts.
● Most of the staff we spoke with said morale in the service was low. They said this was partly due to a lack

of consistency and organisation by the provider and registered manager. They also said it was due to being distressed because of the recent incident when a person had choked and died.

Working in partnership with others

● Three staff told us they were planning to leave the service. One of them said, "I've pretty much given up here. The staff want to do a good job and how can we in these circumstances. A run down building, no communication in the senior staff team and no changes being made. What changes are being made such as building on new bedrooms are the wrong things to do as the basics of the service need to be put right first. After the inspection visit the provider told us no members of staff had left their employment or had indicated they intended to do so.

The provider and registered manager had failed to assess and monitor the quality of care at the service and failed to ensure the environment was fit for purpose. Records were not completed and accurate and people's needs were not fully recognised. This is a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Despite the lack of support from the registered manager, staff were in regular contact with healthcare professionals such as district nurses and speech and language teams.
● The registered manager and nominated individual understood their responsibilities under the duty of candour requirement to be honest with people and their representatives when things had not gone well.

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

● Although residents' meetings had been held these were not well attended. The content of each month's meeting was very similar and there was no opportunity for people to raise other topics. No action had been taken to invite feedback about the service from people who chose not to attend residents meetings.
● Relatives had been invited to complete quality assurance surveys. The registered manager said activity staff would be inviting people to complete pictorial surveys to give feedback about their experience of living in the service.
● There was a suggestion box in the entrance of the service but this was not often used.

The provider and registered manager had failed to develop effective systems to continually improve the service and to gain feedback about the service. This is a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care

● Effective systems were not in operation to support a culture of learning and improvement. The provider and registered manager did not have a process in operation to use incidents as a learning opportunity. Staff were not given the opportunity to reflect on incidents and think about how they could improve their practice.
● The registered manager told us they used internet research to keep up to date with good practice. However, there was no evidence of improvements as a result of this research and no examples of practices introduced to the service.

We recommend the provider and registered manager consider guidance about how to promote a culture of continuous learning and improvement and take action to update their practice accordingly.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider and registered manager had failed to plan people's care with them to ensure it met their needs and preferences. They had failed to ensure that activities were suitable for people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider and registered manager had failed to ensure people were supported in a way which respected their dignity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider and registered manager had failed to ensure people's capacity was assessed in line with the Mental Capacity Act (2005).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider and registered manager had failed to operate an effective system for recording and handling complaints.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

The provider and registered manager had failed to ensure staff had the training required and were competent to carry out their role.