Prime Life Limited

Chamberlaine Court

Inspection report

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Date of inspection visit:
31 May 2022
07 June 2022

Date of publication:
01 August 2022

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Chamberlaine Court is registered to provide accommodation and personal care for up to 38 people, including people with dementia. At the time of our inspection visit there were 36 people living at the home. Care is provided across two floors. A communal lounge and dining area are located on each floor. People's bedrooms were ensuite and there were further communal bathroom facilities located on each floor.

People's experience of using this service and what we found
At our last inspection, we found concerns related to the management of health, welfare and environmental risks, infection control practices and limited and ineffective oversight of the service, meant it did not meet the regulations. In response to our last inspection the provider sent us an action plan telling us how they had strengthened their audit processes, introduced regular daily and manager checks and improved the cleanliness and food hygiene practices at the home. The provider also said the management team was strengthened to provide more oversight at the service to ensure standards were improved and then sustained.

At this inspection, there continued to be a lack of effective oversight to ensure standards and regulations were maintained. Some areas previously identified as a concern, remained. Environmental and health audits now introduced, were either not completed or they were ineffective when completed, in identifying where improvement was needed. Several improvement actions we found during our visit had not been identified through any provider checks at the service. When the manager was away from the home, there was no policies or process to ensure those quality checks continued to be completed. The provider's response to our last inspection and their own action plans had not been fully implemented or effectively followed through.

Environmental risks such as fire safety required improvement. One fire door marked as 'fire door' did not close at all, while another fire door closed at varying speeds. Some first-floor window restrictors did not have tamper fixings in line with recommended guidance. Some of those restrictors could be not as secure as required.

Food hygiene and cleanliness in communal kitchenettes continued to fall short of expected standards, despite additional checks being put in place. Other risks such as cleaning products and hot and exposed surfaces had potential to put people at unnecessary risk. Doors to these rooms were to be locked, yet we saw these doors were open and there was no staff presence to protect people from risks.

Lessons had not always been learned because the same issues remained from the previous inspections.

We looked at infection prevention and control measures under the Safe key question. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively. Infection control systems implemented during a pandemic were in place. However, as health professional visitors, on

the first day, we were not checked to ensure we were negative of COVID-19 and temperature checks were not completed. This was completed on the second day. Staff told us face masks were worn when providing personal care and staff wore masks when they supported people around the home. However, we saw occasions when staff did not wear their face mask correctly.

People's overall feedback to us was mainly positive of a service they received that they felt met their needs. However, we found care plans, care plan reviews and risks associated with people's care were either not recorded, inaccurate or where not followed or consistently understood by the staff team. Staff conversations about the people they looked after and how they needed to be cared for, were inconsistent.

Staff understood their responsibility to report any concerns to protect people from the risk of abuse. There were enough staff on duty to support people, however staff said on the first floor they worked on occasions with one less staff member. We were not confident the dependency tool used to predict staffing hours was accurate as it was based on people's assessed risks which we found were not always accurate. We asked the manager to review staffing hours and the management and deployment of the shift to ensure it met people's expectations. The provider's own audits of call bell times showed in excess of 200 calls per month were in excess of 20-minute delays. From work undertaken by the new manager, we noted call waiting times had recently reduced.

At this inspection, there was another new manager in post so day to day management of this home over the last year or two had seen a number of management changes and instability. It was clear from the conversations with the new manager and the staff team, clear, honest and constructive ways forward were needed to improve people's experiences at the home. The culture and atmosphere of this home was quite negative and from our conversations, a blame culture was noticeable. This is the fourth inspection where the home has achieved the same rating and the culture, ethos and willingness to do the right thing has not yet become embedded in everyday practice.

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 28 April 2022) and there were breaches of regulation. The provider had received warning notices following the last inspection and they had to be compliant with these. The provider was also required to send us an action plan telling us how they would improve and by when. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe, Effective and Well-led which contain those requirements. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has not changed. This is based on the findings at this inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Chamberlaine Court on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified three breaches in relation to safe care and treatment, person centred care and good governance. We found the provider failed to meet the warning notice we issued at the last inspection.

Please see the action we have told the provider to take at the end of this report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

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

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

We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 effective. Details are in our effective findings below.	**Inadequate**
Is the service well-led? The service was not well led. Details are in our well led findings below.	**Inadequate**

Chamberlaine Court

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 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This included checking the provider was meeting COVID-19 vaccination requirements. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors who visited Chamberlaine Court on 31 May 2022 along with an expert by experience. An expert by experience is someone who has experience of using this type of service. Two inspectors returned on 7 June 2022.

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

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

The service did not have a registered manager. The home was managed by a manager and the manager was in the process of registering with us.

Notice of inspection

This first day of the inspection was unannounced. The second day was announced.

What we did before inspection
We reviewed information we had received about the service. We used any information the provider had sent us from their previous annual Provider Information Return. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information we held, such as people and relatives' feedback and statutory notifications, as well as information shared with us by the local authority. We also reviewed the action plan and warning notice response that the provider sent us following our last inspection. This is what the provider told us about the improvements and ways they would ensure actions were taken and continually monitored. We used all this information to plan our inspection.

During the inspection
We spoke with seven people who received a service to get their experiences about the quality of care received. We spoke with six members of care staff and a cook. We also spoke with the manager, a regional manager and a director of elder services (in the report we refer to them as director).

We reviewed a range of records. This included five people's care records and samples of medicine records and daily records. We also looked at records that related to the management and quality assurance of the service, fire safety and environmental risks and records for infection control and risk management.

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has stayed the same. This meant people were not always safe and protected from avoidable harm.

At our last inspection, the provider had failed to robustly manage risks relating to the health, safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found insufficient improvement had been made and there was a continuing breach of regulation 12.

Assessing risk, safety monitoring and management

● In response to the last inspection, the provider said they would improve risk management related to people's care needs and within the environment. At this inspection, we found those risks continued.

● We saw some checks to manage risk were completed but they were not always effective. For example, some fire safety checks required improvement. One fire door marked as 'fire doors' did not close properly, while another fire door closed at varying speeds. Some first-floor window restrictors had their tamper proof covers missing so some of those restrictors were not as secure as required. The director assured us maintenance staff would rectify these issues.

● We found risk management plans were not always updated to reflect changes in people's needs and abilities. Gaps in risk assessment tools in some care plans and associated daily records, meant it was not clear how the level of risk had been assessed and managed which put people at risk of unnecessary harm.

● For example, one person's care plan said they needed equipment for moving and transferring. We found differing information about the equipment the person required, or information to guide staff when transferring the person safely. This person's moving and handling risk assessment was last reviewed on 4 April 2019. This recorded the person was independent with walking and was able to sit to stand. However, following two falls in October 2021 and March 2022 they were no longer able to walk without equipment. Their risk assessment had not been reviewed to reflect these changes.

● One person had a pressure relieving mattress to alleviate skin tissue breakdown and they also had a catheter. We noted their catheter bag had been put directly on the floor by staff because the frame to hold the bag had broken. This poor practice increased the potential for cross infection and risks to their health. We found this person's pressure relieving mattress was not supporting them correctly. As a result, their mattress made the person lean to one side causing them some discomfort.

● Staff had not recognised how their actions put this person at risk. Before we left, we asked the manager to seek district nurse and occupational therapy input to support this person with their catheter and pressure relieving equipment.

● Reviews of people's risks were completed monthly. However, staff's conversations with us showed they did not always know, what support or equipment people required to manage their risks safely despite monthly reviews being completed.

Learning lessons when things go wrong

● There were processes to review and look at patterns and trends, for example through incident and accident management. However, they were ineffective because staff were not always following the provider's policies and procedures for reporting and recording accidents and incidents. For example, one person had completed body maps for two separate incidents of unexplained skin tears and one incident of unexplained bruising. None of these incidents had been put onto an accident and incident form so they could be followed up and further investigated.
● We found the previous three inspections to this home had identified the same issues. Whilst actions had been taken following each visit, those improvement actions have not been learnt, understood and mitigated to drive up standards. We continued to find the same shortfalls at this visit.
● We completed an inspection at one of the provider's other homes in March 2022 which identified similar themes and patterns to here. The director told us they had introduced a 'lesson learnt' memo across the other homes however there was limited evidence to show its effectiveness.

Preventing and controlling infection
At our last inspection we found people were not always protected from the risks associated with poor infection prevention practices which posed risks of cross infection. Although improvements had been made, communal areas of the home remained unclean and further improvements were still required.
● We were not assured the provider was using Personal Protective Equipment (PPE) effectively and safely. Staff did not consistently follow current guidance when using PPE. Whilst PPE was available within the home, we observed numerous occasions when care staff were wearing their masks under their nose or chin in communal areas.
● We were not assured the provider was making sure infection outbreaks could be effectively prevented or managed. Communal lounges and dining rooms continued not to be thoroughly cleaned and free from food debris even after some surfaces were cleaned. Internal cupboards remained dirty and staff or management did not take responsibility to maintain standards.
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. We continued to see uncovered food, food in refrigerators that had passed their expiry date, condiments, dried foods and biscuits continued to remain uncovered. In some cases, there were no labels to show when something had been opened or when it was due to be discarded.
● We were somewhat assured the provider was preventing visitors from catching and spreading infections. The inspection team were not asked about any health screening questions nor were we asked to show evidence of a negative test which is a requirement for inspectors. On the second day, we were asked screening questions before entering the home to determine our COVID-19 status. However, one inspector was not asked to take a temperature test which was what the provider expected. Where records were left out, we saw incomplete boxes, so it was difficult to verify those who had to produce a test result in accordance with guidance to show a negative status.

We found systems and processes were not sufficient to demonstrate risks associated with people's care were effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● The director told us there was no restriction on visiting. Families and friends were able to visit without

formal appointments.

Using medicines safely

● At our last visit we found some 'as and when' medicines did not have a protocol to tell staff when these were safe to administer. We also found pain patch medicines were not being recorded and administered in line with manufacturers guidelines. At this visit we found improved practices so people received their medicines safely.

● Particular medicines requiring two signatures were signed for. Medicines requiring storage in a refrigerator were kept within safe temperature controls.

● We checked time critical medicines and found they were administered at the times people required them although we found one slow release medicine was given 30 minutes before it was due.

● We checked stock counts of boxed medicines and found two examples were the count was not correct. We asked the senior staff to investigate this discrepancy so action could be taken to ensure people received their medicines safely.

Staffing and recruitment

● People gave mixed feedback about staffing levels and we could not be confident, those staffing levels met people's needs.

● Most people said they got the help when needed, however people said staff were extremely busy.

● Staff told us pressures on staffing levels meant they could not provide the high standards of care they would like to provide. One staff member told us, "A lot of time it will be two up and one down, especially at the weekend. When we have four staff up here, it makes a difference." Another explained that staffing levels meant, "They (people) are missing out on the care."

● The provider's own call alarm audit showed in excess of 200 calls per month rang for over 20 minutes. The manager said some alarm equipment was not working and now it was replaced, those calls had been dramatically reduced.

● We did not see people waiting for help; however, we did discuss with the manager about how the shift was managed and that they needed to assure themselves, the tool used to determine staffing hours based on needs, remained accurate.

● At this visit we did not review staff files. We found no concerns during the planning of this visit and people raised no issues about staff's conduct with them. Therefore, we did not review staff files.

Systems and processes to safeguard people from the risk of abuse

● People we spoke with told us they were happy with their care and support and that they felt safe when staff supported them. Comments included, "I have no worries about that (safety)" and "Just everything makes me feels safe."

● However, one person told us whilst they felt safe with staff, they did not always feel safe from other people living at the home. This person told us about events that put them at risk through another's person's escalating behaviours. The provider had sent us notifications about important events that required certain instances to be referred to us and the local authority.

● Staff told us they had received training in how to keep people safe. Staff were confident to raise concerns of poor care with the manager or provider.

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 good. At this inspection this key question has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Supporting people to eat and drink enough to maintain a balanced diet
● We could not be confident that people who required support, assistance and encouragement to maintain good hydration and nourishment, received effective support.
● We looked at one person's food and fluid charts over the last three days leading up to the day of our visit. On two of those days there was no evidence of the person being offered any drinks between 6.00pm and 8.00am the following morning. Following our visit, the provider told us some fluid records were stopped following advice from the GP if a person had achieved their fluid goals.
● Staff told us they completed food and fluid diaries some time afterwards which meant we could not be confident those records were accurate. We asked one staff member completing these records if they were accurate. They said, "Admittedly sometimes it may not be, but we just do the best we can."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People had their needs assessed before they moved to Chamberlaine Court. Assessments formed the basis of their care plans. However, when people's physical and mental health changed, those ongoing assessments and care plans were not always completed or changed to provide staff with the up to date information to provide the right levels of care. Care staff said, "Care plans are reviewed every month, we don't get asked for input as to how people are or if there are any changes."
● People's outcomes and people's needs were not always provided in a person-centred way. For example, one person's care plan said they needed hoisting to sit in a chair and they used a wheelchair to mobilise. The person themselves told us they had not got out of bed for some time and staff only hoisted them to help with personal care. They told us they 'wanted to feel the fresh air on their face' but never went out. Staff told us the person couldn't go in a wheelchair because their legs had become retracted. There were inconsistencies between what the person told us, the person's care records and staff who supported them.
● Systems needed better oversight to provide assessed care and support inline with people's individualised care plans. This was important to ensure people who required support to minimise the risks of falling or developing skin tissue breakdown, continued to receive the right support.
● Staff were not always clear who needed repositioning, the reasons why and what time frequency. We found records were not consistent and repositioning records were not always completed at the required intervals. One staff member told us, "Used to be a chart on the wall but that's gone now, it's down to communication….it's a guessing game all the time." When we asked about one person being repositioned, a staff member said, "I'm not sure if we should or not."
● Despite a lack of consistency with pressure care and repositioning management, we found no one who had a pressure area that had deteriorated.

There was no effective and consistent person-centred approach to the ongoing assessment of people's needs. Systems had not been established to assess and monitor this aspect of people's lives. This placed people at potential risk of harm in relation to their well-being and mental health. This was a breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

● Staff training and refresher training had been identified as requiring improvement. The manager told us additional training had been provided to improve staff's knowledge in fire safety, food hygiene and moving and handling.

● However, we found the training was not always implemented effectively into practice. For example, we found issues continued around infection control, care planning and risk management and the recording and reporting of incidents.

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.

● Where people had restrictions placed upon them, authorisations were approved. In one example, conditions had been applied. However, there was no effective risk assessment to show how the condition would be met. The application had also expired. Another application had been made some months ago with no follow up or intervention plans whilst the approval was being considered.

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

● We were not confident people received the right support. We saw evidence that medical professionals were involved, however we could not be confident that in all cases, that support was sought promptly. It was our intervention that sought help for a person who was on a mattress and a bed that following a district nurse referral, said needed a bigger bed and made adjustment to their mattress setting.

● Two people had oral hygiene assessments which stated they needed assistance with their oral health care which was included in their personal care plans. However, their personal care plans stated they did not need assistance with their oral health. This meant that staff had no guidance as to how they should support these people to maintain their oral health which could impact on their food intake, their wellbeing and their physical health.

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

● People lived across two floors and they had their own bedroom with ensuite facilities.

● People we spoke with liked their room and said they could personalise their room if they wanted with their own possessions.

● At a previous inspection, we found communal dining rooms were locked. At this inspection, we found

these communal dining doors were to be locked to reduce people's exposure to certain risks. However, during this inspection visit we found these rooms on occasions were open with no staff presence. Equipment and materials in those rooms had potential to cause people injury or harm. There was no effective management of this risk. The manager told us those doors should remain locked when not in use.

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 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.

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

At our last inspection, the provider did not demonstrate effective governance, including assurance and auditing systems or processes. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection not enough improvement had been made and the provider remained in breach of regulation 17. The provider failed to meet the warning notice we issued at the last inspection.

● Arrangements to assess and monitor the service remained ineffective. We found missed opportunities to mitigate risks, monitor trends and to learn lessons from their own checks and our inspection findings. The provider's processes to manage risks to people's health and welfare, environmental and infection control risks have failed to improve. This lack of oversight meant people did not have consistently good outcomes.
● Following our last inspection in February 2022, we expected improvements would have been made and the provider to be compliant with all regulations. The provider sent us an action plan telling us how they would improve, the actions they would take and by when. We found the provider's actions had not increased standards.
● For example, reviews of care plans lacked focus which meant information that was important to people were missed and/or omitted. For example, one person's care plan for end of life care had been prepared in September 2019 and stated, "Family will discuss nearer the time." There was no evidence this had been reviewed and the person had been placed on an end of life pathway in October 2021. Another person had been assessed with requiring support to maintain their oral health, yet they did not have oral health care plans in place.
● The provider's audits and checks had not identified that staff were using language which did not accurately describe people's abilities. For example, one person was described as chair bound but could walk with a walking frame with assistance from staff. This formed part of their rehabilitation having sustained a significant injury following a fall. Where areas for improvements and/or amendments in care plans had been identified, they had not always been completed in a timely way which placed people at risk.
● Checks related to environmental risks, food safety, food hygiene and infection control were not effective and robust and had not always identified and addressed shortfalls.
● Processes to safely monitor care records were ineffective. Systems to monitor and mitigate risks to people had failed to identify gaps in risk assessments and where some risks had not been assessed or reviewed for

accuracy. Associated documents to help provide staff with knowledge and information about people were conflicting. Staff conversations showed us there was no consistency in how some people were supported and this left people at risk.

● Staff were not always following the provider's policies and procedures for reporting and recording accidents and incidents. For example, one person had body maps for two separate incidents of unexplained skin tears and one incident of unexplained bruising recorded in April and May 2021. None of these incidents had been put onto an accident and incident form so they could be followed up and further investigated.

● Checks of staff practice had failed to identify staff were not consistently following the most up to date infection control guidance. This related to staff not wearing face masks correctly and not ensuring the home environment was effectively cleaned.

● As visiting professionals, the inspection team on the first day was not asked to show proof of a negative test as required, nor where the provider's policies followed relating to temperatures being taken.

● There were limited and ineffective provider audits to ensure checks and audits were driving improvements. We saw one compliance audit completed in March 2022 identified a number of significant shortfalls one month after our previous inspection where we issued enforcement action. This audit was focussed on scoring a percentage rather than following up on those actions to embed improved practices. The provider's own score rated the service four % above inadequate. Some actions were identified and were the same as what we had previously reported on in February 2022 and what we found again at this inspection visit which was not consistent with our findings.

The provider failed to make and sustain improvements to the service and comply with regulations and the warning notice we issued. Service oversight and governance systems were ineffective. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● A new manager had been appointed since our last visit. They told us they were in the process of registering with us and making improvements at the service. The manager had held meetings with staff and was in the process of making changes within the staff team to strengthen the team and improve the quality of care at the home.

● We spoke with the director and regional manager about what they thought of the home's progress since our last visit. They both told us standards were much better. They told us about investments made into the environment, with a conscious effort at making the home more tailored to supporting people with dementia.

● Staff were clear about their day to day roles and responsibilities, however, where tasks were delegated to others, we found limited oversight from management ensured things ran smoothly. For example, in the completion of important daily records to monitor people's health and systems to ensure care plans remained accurate and relevant.

● Staff told us they valued their role in caring for and supporting people but did not always feel valued or appreciated by the management team. Comments included: "We don't get appreciated for the effort and the work we do", "The atmosphere isn't great. If you are happy it rubs off on them (people)" and, "We don't get any recognition when we go out of our way."

● Our conversations during the inspection with management and staff indicated towards a culture of blame.

● Despite our findings people were satisfied with the service provided and spoke positively about the staff who cared for them.

● Whilst there were limited formal processes to capture people's views, people told us managers and staff were always available to speak with if needed. People told us management changed quite a bit, however if they had an issue, they would raise it.

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

- The manager understood their responsibility to be open and honest when things had gone wrong.
- The provider had met the legal requirements to display the services latest CQC ratings in the home and on their website.

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 failed to do all that was possibly to ensure people received their care that was personalised to them and focussed on improving or maintaining their overall health and wellbeing.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider continued not to operate and ensure robust quality systems or processes were fully effective to monitor the service appropriately, including people's safety.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider continued not to adequately assess and protect people against risks by doing all that was practicable to mitigate any such risks.

The enforcement action we took:

We issued a warning notice because this was a repeated breach of regulation 12.