

Windsar Care Limited

Heathlands Care Centre

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

Heathlands Care Centre is a residential care home providing personal and nursing care to up to 46 people. The service provides support to older people including with dementia and other mental health needs. The service is provided over two floors. At the time of our inspection there were 16 people using the service.

People's experience of using this service and what we found

The provider did not operate effective quality assurance systems to oversee the service. These systems did not identify shortfalls in the quality and safety of the service or ensure that expected standards were met. People's, relatives' and staff's feedback were not continuously used for making improvements to the service. We are mindful that relatives' and professionals' feedback was positive compared to our inspection findings and observations. To be fair and proportionate, we have included some of their feedback in the report.

The provider did not ensure consistent actions were taken to reduce risks to people and plans were not in place to minimise those risks. The provider did not ensure their safeguarding systems were operated effectively to investigate and follow the provider's procedure after becoming aware of an allegation of abuse. Effective recruitment processes were not in place to ensure, as far as possible, that people were protected from staff being employed who were not suitable. The management of medicines was not safe. Staff did not always follow correct infection prevention and control processes. Not all staff were up to date with, or had received, their competency checks and mandatory training. When incidents or accidents happened, they were not fully investigated, and there was little evidence of any lessons learned, or themes and trends reviewed. The provider did not ensure that clear and consistent records were kept for people who use the service and the service management. The provider did not inform us about notifiable incidents in a timely manner.

Staff deployment was not always managed effectively as we observed people did not always receive timely support. The provider did not ensure people's hydration and food intake was consistently monitored and managed. People were at risk of social isolation because the provider did not ensure activities were more personalised and people had opportunities for social engagement according to their interests. The provider did not ensure the premises were suitable for people living with dementia or comply with the Accessible Information Standard. The care plans did not consistently contain information specific to people's needs and how to manage any conditions they had. Staff did not have detailed guidance for them to follow when supporting people with complex needs.

We have made a recommendation about provider seeking training for Legionella awareness and how to manage the fire safety of the building.

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.

We observed that the interactions between people and staff were better but we also observed some practices still had to be improved. Staff upheld people's privacy and responded in a way that maintained people's dignity. People's families and other people that mattered felt they were involved in the planning of their care. Most relatives said they were kept informed about their relative's health and welfare. Relatives were positive about staff being kind, caring and respectful. Relatives felt they could approach the management or staff with any concerns and felt they had better communication and relationships with the service. The home manager appreciated staff's work, contributions and efforts to ensure people received the care and support. Staff felt they could approach the management team for support and advice. Relatives felt people were safe living at the service and relatives felt their family members were kept safe. Staff described their responsibilities to raise concerns and report incidents or allegations of abuse. They felt confident issues would be addressed appropriately.

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 inadequate (published 19 August 2022). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations. At our last inspection we recommended the provider sought advice and guidance on how to make the environment more dementia friendly and ensure they met the principles of Accessible Information Standard. At this inspection we found the provider had failed to act on both recommendations therefore had not made further improvements.

Why we inspected

This inspection was prompted due to the previous rating and to follow up on a warning notice.

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.

This inspection was carried out to follow up on action we told the provider to take at the last inspection. We have found evidence that the provider needs to make further improvements. Please see the safe, effective, caring, responsive and well-led sections of this full report.

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

Enforcement and Recommendations

We have identified breaches in relation to quality assurance; risk management; safeguarding alerts management; notification of incidents; record keeping; effective and person-centred care planning; assessing and reviewing capacity and seeking consent; management of medicines, infection control; suitability of the environment for dementia; staff deployment, training, competence, and recruitment at this inspection. We have made a recommendation about further training regarding legionella safety management for the maintenance staff.

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.

Please see all the actions we have told the provider to take at the end of this report.

Follow up

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

Special Measures

The overall rating for this service remains 'Inadequate' and the service remains 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate ●

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate ●

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement ●

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement ●

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate ●

The service was not well-led.

Details are in our well-led findings below.

Heathlands Care Centre

Detailed findings

Background to this inspection

The inspection

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

As part of this inspection we looked at the infection control and prevention measures in place. 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 four inspectors, a specialist advisor and 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. They contacted people's relatives for feedback about the service.

Heathlands Care Centre is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Heathlands Care Centre is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager

This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations. At the time of our inspection there was not a registered manager in post. However, a new manager had been in post for one month and had submitted an application to register. We are currently assessing this application. They supported us on both days of inspection. We will refer to them as 'the home manager' throughout the report.

Notice of inspection

This inspection was unannounced.

What we did before the inspection

Prior to the inspection we looked at all the information we had collected since the last inspection of the service including information from the local authority and notifications sent us. A notification is information about important events which the service is required to tell us about by law. We used all this information to plan our inspection.

The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection

We spoke to the home manager, the deputy manager, maintenance person and cleaner, and gathered feedback from 15 members of the staff team. We observed interactions between staff and spoke to 2 relatives of the people who use the service. We reviewed a range of records relating to the management of the service, for example, records of medicines management, risk assessments, accidents and incidents, quality assurance systems, and maintenance records. We looked at 9 people's care and support plans and associated records. We looked at two staff files in relation to recruitment. We briefly spoke to the nominated individual on the second day of the inspection. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

After the inspection

We continued to seek clarification from the home manager to validate evidence found. We looked at further records and evidence including recruitment information for 2 staff, quality assurance records, training data, meeting minutes, and policies and procedures. We spoke to 8 relatives about their experience of the care provided to their family members. We contacted 22 professionals who work with the service and received 6 responses.

Is the service safe?

Our findings

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

At our last inspection we rated this key question inadequate. At this inspection the rating has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong.

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12(1) 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.

- The provider and senior staff did not demonstrate they reviewed and reassessed people's risks to ensure people were consistently protected from avoidable harm. Risk assessments did not include enough information about how identified risks were to be managed or mitigated to ensure people's safety.
- There was little evidence of oversight or audits regarding the risk management and changes of care delivery which put people at risk of harm or injuries.
- For example, people's skin integrity was not managed safely or effectively. One person's feet had injuries to their toes which staff had recorded were caused by 'inappropriate footwear'. Actions were noted for staff as to how to help this person. However, over 2 days of inspection we did not observe any of these actions to be carried out. The person was still wearing the shoes reported to have caused the wounds. Staff told us the person would refuse to take the shoes off. The manager told us a podiatrist referral had been made and the person had been seen by a podiatrist recently. Records indicated most people had been seen on the same day but there was nothing noted about these specific wounds on the podiatry record for this person.
- Another person had developed a wound even though they were fully mobile. It was noted in the person's care plan an air mattress was used to help with this wound. They also had to have incontinence products to be used but staff had not arranged for these to be provided, even though the relative raised it with senior staff a while ago. Records indicated staff were to apply specific cream to treat the wound but there was no evidence staff had applied this.
- We reviewed other people's notes and found they were supported to go to the toilet but there were long gaps in between the checks. For example, people would be supported to the toilet at 9am or 11am and then only at 6pm or 6:30pm. Care plans stated 'change pad regularly' with no further detail provided regarding what that interval would be. This meant people were put at risk of skin damage and acquiring wounds because staff did not ensure people received personal care regularly.
- At the last inspection, we had raised concerns about operating mattress settings to ensure people were on the right setting to support good skin integrity. At this inspection, the home manager told us the maintenance staff member was responsible for checking air mattresses and ensuring they were set at appropriate weight.

- We spoke to the maintenance staff member who told us staff would inform them if there was a problem. The maintenance staff member was clear that they did not check mattresses in relation to whether the settings were accurate. They were able to demonstrate how to set the mattresses to within 10kg settings.
- Of the 11 mattresses we checked, we found 8 to be in excess of 10kg different from people's weight. This meant people were at risk of skin damage because the provider did not ensure staff had an understanding of how to set pressure relieving mattresses correctly. Staff noted the mattress was checked but they did not know the setting was wrong.
- Records also did not assure us that planned safety checks on people were happening. For example, one person had to be checked every 20 minutes at night as part of the risk management following the incident. However, staff could not locate the records to demonstrate these checks had been done consistently.
- Accident and incident records had not been fully and consistently completed. We were not assured these were completed in line with provider's policy to support people's wellbeing and safety monitoring.
- We found some incidents were recorded on behavioural charts and not reviewed to identify any further action to support people. We found a number of serious incidents, inconsistently recorded on different forms, but these were not reviewed to identify further risk mitigation for people and update their records accordingly.
- The provider did not ensure incidents and accidents were thoroughly reviewed to help identify themes or trends that would require further action to be taken. We asked the manager to send us any other analyses completed, but they were only able to send an analysis for October 2022.
- There was little evidence that the cause of accidents and incidents had been investigated to help ensure actions would be taken to prevent recurrences.

The registered person did not consistently assess risks to the health and safety of people. Insufficient action had been taken to mitigate identified risks. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- At the last inspection, we found the provider did not ensure the premises and safety of the living environment were consistently checked, and managed, to support people to remain safe.

Enough improvement had been made at this inspection and the provider was no longer in breach of this part of the regulation 12.

- During this inspection, we found that premises and equipment risks were effectively assessed, documented, mitigated and reviewed..
- Maintenance checks were routinely and thoroughly completed. Examples included fire safety, Legionella prevention, portable appliance testing, gas safety, water temperature checks and electrical safety.
- Minor improvements to fire safety were completed since our last inspection. The fire service checked these and were satisfied the service was compliant with the relevant regulations.
- Records showed either the maintenance person or suitable contractors completed servicing, checks and repairs to premises and equipment. Although we noted the maintenance staff had to have further training in legionella awareness as part of the recommendation in the risk assessment, but this was not completed yet.
- Mock evacuations were completed; however, none were simulated at night. The maintenance person explained they did not work out of hours. We highlighted this matter to the home manager who explained more staff would be trained in how to run simulated evacuations.

We recommend that suitable staff are trained in Legionella awareness and how to manage the fire safety of the building.

Using medicines safely

At our last inspection the provider had failed to ensure safe management of medicines. This was a breach of regulation 12(1) 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's medicines were still not managed safely.
- We looked at medication administration records (MAR) charts for all the people in the service. We found missing signatures and there was no explanation for this. There were no incident forms completed for those gaps to check if it was only a recording error or if the person had not been given the medicine.
- People were prescribed 'when required' (PRN) medicines to help them manage different conditions. There were only a few PRN protocols available. They did not contain clear information specific to the person such as symptoms to look out for, how people expressed themselves when in pain or needing a particular PRN medicine, any side effects to look for, the correct dose of medicine or when staff should review it.
- Another person was prescribed 0.5 mg PRN medication to help with distress or feeling anxious. However, staff were giving double the dose to the person. There was no PRN protocol in place to guide staff how to help the person first and only then to use medication as the last resort. There was no clear rationale recorded when the PRN medication was given, staff had only noted 'agitation' as the reason.
- When people used pain relief patches, the records were poorly maintained. For example, staff recorded the same day for application and removal of the patch, even though it was a 24-hour patch. There were gaps on some dates, and nothing was recorded to indicate what was done regarding the patches.
- After the inspection, the manager sent PRN protocols to us. However, they still lacked details, personalisation and correct information to ensure people received the right medication when needed.
- In the MAR charts, staff used letter codes as part of the administration process. However, when codes were used, staff did not record the rationale for it and what was done about the medicine; or did not use codes at all.
- Staff also did not record consistently when PRN medicines were given. The manager explained there was a separate sheet for PRN medicines administration that was supposed to be used. We looked at some MAR charts together where PRN was given, and it was clear staff did not use MAR charts nor the separate forms consistently to record occasions and the rationale for PRN medicines given.
- Staff also counted medicines and recorded on count sheets. The records had gaps and did not record the number of medications used consistently or accurately.
- One person had a care plan for 'covert medication agreement form'. However, it was noted that the person "was not able to swallow, [person] is on liquid diet". The form was not fully completed, and it was signed by a family member who did not have a right to sign any records.

Medicines continued to be not managed safely. 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 observed administration of medicines and saw the registered nurse was talking with people with respect, explaining the reason for administration and supporting them to take their medicines at their own pace.

Staffing and recruitment

At the last inspection, the provider did not ensure all the information was obtained required by the Regulations to ensure the suitability of all staff employed.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 19.

- The provider did not operate effective and robust recruitment and selection procedures to ensure they employed suitable staff.
- The provider had not ensured all of the required recruitment checks had been completed before staff started work. The recruitment records of four staff did not contain all of the required information such as evidence from previous employment regarding staff's conduct and verifying reasons for leaving.
- In one example, we were not assured that the provider completed a Disclosure and Barring Service (DBS) check prior to staff commencing work at the service. We asked to see the evidence, but the provider did not provide it to us. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
- Failing to obtain all of the required recruitment information before allowing staff to work, placed people at risk of receiving care from unsuitable staff.

The registered person had not obtained all the information required by the Regulations to ensure the suitability of all staff employed. This was a continued breach of Regulation 19 (Fit and proper person employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- At the last inspection, the provider did not ensure staff were deployed in a way that kept people safe or in a manner that met their needs.
- During this inspection, we found the provider still used agency staff to ensure the right numbers and the mix of staff. The home manager said they had reviewed numbers of staff and people's support needed to decide on numbers of staff needed per shift.
- Relatives had mixed views regarding the numbers of staff. Some felt there were not enough staff to support people and spend some quality time with them. They said, "When I visit there always seems to be ample staff on. I usually visit once a week" and "It seems like it that there are sufficient carers there" and "I know they are very busy sometimes but there is always at least one member of staff left in the dining room. [The deputy manager] comes in and sits in the dining room all the time. I don't think they leave anybody on their own".
- However, other relatives felt this needed improvement still and said, "I think it varies, certainly not at weekends. There has been a lot of staff changes since they have opened. Just not sure really", "No. I have been there when there is no staff around. When I have arrived there, my [relative] was still in bed and they don't have enough staff. My [relative] is not showered every day and I don't know why" and "Will there ever be enough! I think there should be more there" and "No. Staff do seem to be changing and it is short in numbers. Recent management changes have resulted in 1 carer to 2 residents" and "Weekends is a different kettle of fish. Some manager should be around at weekends to have oversight of this. There are a lot more staff here today than there normally are. I wish there this many staff here every day".
- Some staff agreed there were enough staff to do their jobs and support people. However, some felt there were not enough staff and it affected the way they carried out their duties according to their priorities.
- We also observed the management of agency staff was disorganised and three agency staff had to be taken off the floor in the middle of the shift to complete their induction. The deployment and organisation of the staff team did not ensure people could be attended to in good time.

The registered person did not ensure appropriate deployment of competent, skilled and experienced staff so that people were safe and had their needs met. This was a continued breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

- The provider did not ensure the system in place to protect people from abuse and improper treatment was used effectively.
- We found incidents where safeguarding alerts were not raised to ensure they were investigated properly. By failing to inform the relevant authorities of this allegation of abuse, this placed people at risk of ongoing harm or abuse.
- This meant the provider and the staff were not fully aware of procedures to follow in accordance with the Berkshire safeguarding adults policy and procedure.
- As part of their role, staff must receive safeguarding training that is relevant and suitable for their role. Staff had not completed this training, and people were put at risk of harm.
- Although the manager responded to information given about alerts and raised it with the local authority, we could not be assured this practice would be sustained. It was identified during our inspection and not through the provider's own governance checks.

The registered person did not ensure the provider's systems and processes to protect people from abuse and improper treatment were operated effectively and consistently. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

- We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- The service was generally clean and tidy. However, we found some standard and deep cleaning was unsatisfactory.
- Some mattresses, cushions and chairs were observed with splash marks, dust and crumbs.
- The correct bins were not used consistently throughout the service.
- Robust records of cleaning were not continuously maintained. The cleaner we spoke with was unsure of which forms to complete for recording the cleaning they completed.
- The home manager was informed of these observations. An infection control audit was completed 10 October 2022 and detailed some of these points. There was an action plan in place, but more effort is required to ensure a clean environment.
- We were somewhat assured that the provider's infection prevention and control policy was up to date.

The provider did not ensure processes and systems in place were followed by all staff to meet their responsibilities in relation to preventing and controlling infection. This was a 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 preventing visitors from catching and spreading infections.
- We were assured that the provider was supporting people living at the service to minimise the spread of infection.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was responding effectively to risks and signs of infection.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

- There were no restrictions on visiting people, and this was in line with government guidance.

Is the service effective?

Our findings

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

At our last inspection we rated this key question inadequate. At this inspection the rating has remained inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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

At the last inspection, the registered person had not ensured people's care and treatment was appropriate and met their individual needs. This was a breach of Regulation 9 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 9.

- The provider had not ensured that the service effectively met people's needs and positive outcomes were being achieved consistently for people.
- Care plans had been reviewed since the last inspection. However, the records did not include enough or personalised information for staff to follow so that they could meet individual people's needs safely and effectively.
- For example, one person had a condition that required support with medication to control it and prevent further deterioration. The care plan stated to monitor sugar levels and actions to take to prevent the person's condition deteriorating such as "if blood sugars are consistently over 18 mmols diabetic nurse to be contacted" and "if blood sugars were high and there were other symptoms then resident should be admitted to hospital". However, there was no clear information in the care plan what specific symptoms staff needed to look for to inform the decision to admit to hospital. We looked through medical records, but these were not kept consistently and did not indicate what support the person was provided with when their blood sugars were high. When we informed the manager about this, they said the training was arranged for staff around the condition. However, we raised our concerns around the lack of information and guidance for this person and the seriousness of their condition at this time, regardless of the training in the future. The manager was not able to tell us more about this part of the care plan or support needed.
- Some people needed support with their behaviour. For example, one person had information around how to support them when they were distressed or irritated. We observed this person throughout the inspection. When they displayed such behaviour, staff attempted to encourage the person to cooperate, but it was unsuccessful. The staff did not show knowledge of ways to manage such behaviour that were indicated in the care plan.
- The care plan indicated that staff could contact family to come in and support the person. Although having family involvement was important, reliance on them to manage someone's behaviour indicated staff's inability to identify the most effective provision of care for this person and provide that support during

those vulnerable times.

The registered person had not ensured people's care and treatment was appropriate and met their individual needs. This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

At the last inspection, the provider did not ensure all the staff were competent, skilled and had up to date training in order to carry out their role when supporting people and perform their work.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

- Staff did not always have the knowledge, skills and training they needed to meet the complex and diverse needs of people using the service and to ensure their safety and welfare.
- We reviewed the training matrix provided to us after the inspection which recorded different training topics. Not all staff had completed the training required for their roles such as dementia, epilepsy, diabetes, falls prevention, mental capacity and first aid.
- Only six staff had moving and handling competency checks completed according to the records we found. A number of people needed support with transfers and support to manage risks around it. However, the provider did not ensure all staff involved in people's care were assessed as competent to carry out these tasks.
- We observed whilst staff used hoists for moving and handling calmly, there was very little engagement with people. People were not informed what each step meant for them to ensure they did not get distressed or anxious whilst the task was being completed.
- We also observed that staff did not follow the correct procedure to transfer one person. Staff members pulled the person up under the arms so they could reach the handles of the standing hoist. The sling was below the person's shoulders and not used properly to support them to stand up rather than pulling them. Although the rest of the process was done gently, the staff did not understand they had put the person at risk of injury.
- The CQC Smiling Matters report (July 2019) outlines findings on the need to focus on oral healthcare for people. We found the provider's training policy did not include training on oral care. Oral health training is also now included as best practice mandatory training. Training records showed only four staff had received training in this topic.
- Staff completed the Care Certificate as part of their induction. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme. To be awarded the Care Certificate the person must acquire knowledge and demonstrate understanding of the knowledge acquired as well as demonstrate and be assessed as competent in the standards. The home manager was not sure all staff had assessments completed and this was one of the actions to complete.
- We spoke about induction set up. The home manager said staff had to complete training and go through all the information for 5 days. We questioned the home manager regarding the amount of information provided for staff and how much learning they had to complete. The home manager could not provide information about how they had checked staff knowledge and learning in this area.
- Our observations confirmed staff were not always confident, knowledgeable and competent to support people in a consistent way and guided by best practice. This was particularly apparent when staff were

supporting people who had different stages of dementia, could not communicate verbally and showed signs of being distressed or anxious. For example, one person was walking around and saying that they "should be dead". We spoke to them a few times to support them. However, we did not see staff actively engaging with them, demonstrating they knew the person well or making them feel they mattered to the staff.

- Some relatives added, "Not really, [I don't think staff have the training and skills]. I would say 50% of the staff do...I think they need a lot more training with dementia", "The managers do [have the skills and knowledge] but with the regular turnover of staff, I don't think so" and "Now that's a tricky one. Some of them are OK, others are not so".

The registered person did not ensure all staff were competent, skilled and had up to date training in order to carry out their role when supporting people and perform their work. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2019 Regulations 2014.

- After the inspection, the provider informed us that staff had training for diabetes to ensure awareness about caring for people with diabetes. Staff had also attended training for national early warning score (NEWS2) and physical deterioration and escalation tool (RESTORE 2) to understand when to raise alert and escalate concerns to the appropriate health professionals. The home manager also commenced work with professionals to support people's oral care.
- After the inspection, the provider also informed us they were putting a process in place to ensure any new staff would receive the care certificate training and have their competency assessed moving forwards.
- Staff had one-to-one supervision meetings with the manager to review their practice and discuss further development needed. Staff agreed they had meetings with the manager. They felt supported by the manager and senior staff.
- Some relatives were more positive now about staff skills and said, "I do now since the new staff. They are very knowledgeable now and if they don't know something, they contact someone who does and come back to me", "I do now [think staff have the skills and knowledge] but not at first" and "Originally no. But since the last CQC visit they have undertaken extensive training".
- Professionals added, "[Professionals] carry out regular visits to the home and during these visits, there has been evidence of good practice, interaction and engagement between residents and staff... [The home manager] has identified gaps in process and training. [They] are also developing a training plan and the identification of Senior Health Assistants to help structure the floor, coordinate the responsibilities of the on-shift staff, empower the staff in regard professional development, and improve leadership on the floor" and "There have been feedback from our staff that permanent staff have the knowledge of residents and skills to care for the residents but there have been concerns about staff knowledge of residents when temporary staff were present at home".

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

At the last inspection, the provider did not ensure people's fluid and food intake was consistently managed.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.

- People were at risk of malnutrition and dehydration.
- We observed people who were nursed in bed did not have fluids within reach. They could not assist themselves to drink. Their call bells were also secured to the wall, so they could not call for a staff member.
- At lunch, there was a choice of meals. Some people were able to state which dish they preferred. However, others had meals provided to them by staff without being asked or shown the food first.

- One person refused to eat their lunch. Staff attempted multiple times to provide the same food to the person. They were not offered any alternatives or asked if they preferred another meal. Staff did not use an approach such as 'retreat and return', where a meal or snack could be offered later when the person was relaxed.
- One staff member was observed trying to push the spoon into a person's mouth. This was because the person did not open their mouth voluntarily. The staff member did not know techniques to promote the person to open their mouth to take the food.
- Staff did not know what was on the menu for the day. No menus were provided on tables. Instead, they were displayed in very small print and pictures on a pinboard and were difficult to read.
- Snacks were locked away and inaccessible to people without staff. We observed a fruit bowl was in the kitchenette cupboard. We were told this was due to people touching the fruit. This did not promote small, frequent snacks throughout the day.
- Powders used to thicken drinks were in a cupboard which was unlocked. People could access the powder by opening the cupboard door, putting them at risk if they were to ingest the powder. The deputy manager locked the cupboard after we pointed this out.
- Access to drinks was not readily available without staff support. There were no jugs of fluids or cups left out so that people could help themselves when they wanted.
- One person who required assistance waited one hour after lunch commenced for their meal to be served, as all staff were with other people in the dining room. They were in front of other people who were eating and drinking.

The registered person did not ensure the nutritional and hydration needs of service users were met appropriately. This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We also observed some staff assisted people eating and drinking patiently and in a caring manner. They assisted people on a one-to-one basis.

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

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

At our last inspection provider failed to ensure the requirements about seeking consent were followed and using restrictive practice were in line with legislation and guidance. They did not keep complete and accurate records of consent and decisions made by people or on their behalf in their best interests.

Not enough improvement had been made at this inspection and the provider was still in breach of

regulation 11.

- We were not assured people's human and legal rights were always understood and respected.
- We looked at people's mental capacity assessments, but these were generic, not decision specific and lacked personalisation. For example, one person had a 'consent and capacity form' completed and consequently staff deemed the person lacked capacity just because they had 'dementia'. The assessment did not indicate specific decisions that had to be made. It did not include information to say if the person was presented with information about that particular decision in the way they understood and communicated. The form recorded that a family member was present and agreed the person lacked capacity to make decisions. This did not evidence the person's views had been gathered, reviewed and considered. The assessment was done with a prejudgement the person lacked capacity.
- There was a form signed to agree to share information with professionals regarding medical history and any treatment required, which was signed by relatives. There was no evidence the relatives had legal right to sign this document.
- There was a tick list used for people to indicate the capacity they had to make various decisions. Although one person had recorded 'no' to all aspects, there was no evidence to show any further assessments were done to review each separate decision and where the person could give consent and make an informed decision.
- Another person's records indicated they had no capacity to make decisions. However, we observed staff approaching the person to ask whether they wanted their meal and they were able to make a decision about that.
- Staff did not demonstrate they followed best practice and knowledge around assessing mental capacity, to support decision making and best interest decision making. Records did not evidence that staff completing mental capacity assessments had tried to seek the person's thoughts or wishes.
- Some consent documentation was signed by a third party without it being clear that they had the legal authorisation to be doing so.

The registered person did not ensure the requirements about seeking consent were followed and in line with legislation and guidance. This was a continued breach of Regulation 11(1)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following our inspection, the provider informed us that a new mental capacity assessment had been developed and put in place. The provider also told us they had taken action to confirm which relatives had lasting power of attorney for health and welfare.
- We did not observe any restrictive practices used at this inspection.
- The provider had made DoLS referrals, where appropriate for people living in the service.
- Relatives were positive about support given around decisions and seeking consent. They said, "Yes [the staff] do. My [relative] can get agitated because of the [condition]. Some staff are particularly good at handling that and now they put those staff on to help [the person]", "Yes, I think so. [The staff] seem to have a close bond and they use [the person's] name and [the person] knows them too", "[The staff] always ask [the person] but [the person] only has one word answers, yes or no" and "Yes, the staff do stop & listen to what [the person] says even though it is a lot of rubbish".

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

At the last inspection, the provider did not ensure that people were always referred to healthcare professionals when their health deteriorated or changed. This was a breach of Regulation 9 (3) 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 9.

- Staff worked more effectively when people needed to be referred to healthcare professionals when their health deteriorated or changed. Staff communicated effectively with healthcare professionals about different needs.
- Staff could contact the GP surgery and record in advance of the GP's round any people that needed assessment. A nurse from the surgery attended instead on occasions.
- Out of hours calls to healthcare professionals were also used by staff. This included the rapid response team, who often dealt with minor ailments or injuries.
- Other healthcare professionals such as dentists, podiatry, specialist nurses, occupational therapists were involved as required, which ensured people were supported to maintain a healthy lifestyle.
- Relatives said, "[The home manager] is amazing... Things have changed. My [relative] hasn't had [an infection] and is as happy... We are so pleased with the changes" and "Yes every time there is a concern, they call me and say they are getting the doctor. I feel they are very much on the case".
- Professionals said, "The current manager is attending the online training that is on offer and prompting other team members to attend too. I find [the home manager] to be responsive and engaging. When requesting to book a visit, [the home manager] has always responded by saying 'visit any time'", "[Different professional teams] have been consistently supporting the care home to improve the standards of care", "The home is well supported by health services and engages positively with this support. [The home manager] has been proactive in ensuring that residents have access to dental care and close ties to the NHS further support in the healthcare tasks" and "The home manager and staff were very helpful and knew in advance and sent us detailed medical history for us to examine the residents".

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

- At our last inspection, we made a recommendation for the service to research and implement best practice guidance about adapting the environment for people living with dementia.
- The service has failed to take action to ensure that the premises and equipment is suitable.
- We observed activities taking place with 5 people at the end of a corridor. The space was not designed for this amount of people, it was crowded, and a person's large wheelchair blocked a fire exit.
- There remained a lack of spaces for people to see visitors and undertake social activities, other than in their bedroom.
- Light switches were not highlighted in a different colour to the walls. This made it harder for people to see them and promote their use. Taps remained unsuitable as they were not colour-coded in a way that helped people with dementia understand hot and cold water.
- The outdoor walking space and route was not used regularly. Despite benches and landscaped gardens, there were no covered areas outside for people to sit under.
- There was exterior CCTV in operation, however there was no appropriate signage or information in place in accordance with guidance set by the Information Commissioner's Office.
- The only bathtub was out of order. It was located on the first floor, but all people using the service live on the ground floor. Staff explained this was not used since the opening of the building. The manager added that no one expressed any wish to use it. However, there was no evidence of such conversations held. After our inspection, the service sent information to show the bathtub was fixed and operational.
- The home manager explained that a cinema was created. When we checked, this was a large screen TV on a wall with four chairs in front. People were assisted to the cinema room once a week in the afternoon to watch movies. Drinks and refreshments are provided. However, there was a lack of decoration and

appropriate signage to indicate the space is used for entertainment and activities. This is important for people living with dementia who can use visual prompts to understand their environment.

- There remains a lack of tactile, visual and other objects for people living with dementia. For example, items with different textures and aromas. Other than standard fixtures, fittings and equipment there were no items of interest for people who may benefit.
- Coloured plates, bowls and cups were still not in place for mealtimes. These are proven to assist some people living with dementia to comprehend mealtimes and encourage eating and drinking.

The registered person had failed to ensure the premises were suitable for people living with dementia. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Is the service caring?

Our findings

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

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

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

At the last inspection, the provider did not ensure people were treated with dignity and respect. This was a breach of Regulation 10 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 10.

- We observed how staff supported and interacted with people through the inspection. Some staff communicated with people in a kind, polite and calm manner. However, we still observed occasions when staff did not show care and compassion to ensure people were looked after in a caring and consistent way. The service had still to make improvements to ensure all staff consistently treated people as individuals and quickly responded to changing needs. Staff were more focused on tasks than people and their wellbeing. We noted some examples to provider so they could work with staff on making those improvements.
- Relatives felt the staff's support had improved and said it felt more like a home now. They said, "Yes, we love them. I don't think there is anybody here anymore that we feel uncomfortable providing care to [the person]. They are always hugging [the person]", "Most staff here are very caring. Some are exemplary including [staff names] and [staff member] is very good as well" and "Yes, I do think [the staff are caring]. [My relative] has always liked a particular type of music. The other day they were playing [that music] ...I thought that was lovely. I have noticed the staff changes since the last inspection. The home feels it is better run now."
- Professionals agreed support from staff had improved. They said, "The general feedback is that Heathlands care home is developing a positive caring and dignified care. There have been no recent concerns about lack of privacy and dignified care" and "I have definitely seen an improvement within the main area in regard to staff interaction with residents...Staff appear happier, engaging and wearing masks. During one of the visits, I observed [one person] become agitated and verbally aggressive... I noted that the staff supported this [person] in a calm, kind and professional manner".

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

- Care plans were drawn up with people, using input from their relatives and health and social care professionals where available.
- People and their relatives were involved in providing views on the support they received.

- Most relatives agreed they were kept informed about their family member and any changes to their health and wellbeing. They felt involved in the care and support of their relative. Some felt the communication could be improved, and said to us, "[Staff] mostly call me but not always. I have asked them to call me when an outside person comes regarding any health matter, but they don't do this. I ask because I want to be there when the professional comes in. They always call me afterwards but never before!" and "Sometimes they call me but not very often".
- Most people's bedrooms were personalised and decorated how they liked and with items important to them. People appeared well cared for and wore clean clothes and appropriate footwear where needed.
- People's right to confidentiality was protected. All personal records were kept securely and were not left in public areas. Staff understood the importance of keeping information confidential. They would only discuss things in private with appropriate people when necessary.

Is the service responsive?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has remained requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences.

At the last inspection, the registered person did not ensure care and treatment was appropriate and met people's needs. This was a breach of Regulation 9 (Person-centre care) 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 9.

- People's care plans were based on a full assessment, with information gathered from the person and others important to them. However, care plans did not clearly and consistently describe people's preferences, support needed, and desired outcomes.
- For example, in care records for a lady, it was referring to a gentleman and using information relating to him.
- Records had other people's names too meaning the records had been copied from one another without due care to ensure it was personal and accurate for each person.
- Another person had advice from a speech and language therapist (SALT) to use thickener for fluids however this was not yet included in the care plan and the information in the kitchenette area had not yet been put on display. SALT advice was also to provide fluids for the person in an 'open cup' but we observed fluids being given with a cup with a spout on.
- For another person, it was recorded they were managing to use their inhaler themselves. This was not documented within the care plan and then it was confirmed to be incorrect by the home manager.
- The care records had been reviewed at the end of September 2022. The provider did not ensure people's care plans were still relevant. We were not assured, based on our findings, that the reviews were robust enough, reflected changes and did not have a focus on improving people's quality of life.
- We reviewed the daily notes and daily checks completed for each person. The records were still basic, describing mainly tasks completed with little evidence of individualised or person-centred entries and any activities carried out.

The registered person did not ensure care and treatment was appropriate and met people's needs. This was a continued breach of Regulation 9 (Person-centre care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow

interests and to take part in activities that are socially and culturally relevant to them

At our last inspection, the provider did not ensure people were engaged in meaningful activities and were not at risk of social isolation. This was a breach of Regulation 9 (Person-centred care) 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 9.

- Since the last inspection, a new activity coordinator has been employed to help manage people's activities and social interactions. The home manager said on the weekends the activities were delegated to staff to complete.
- However, still more needed to be done to ensure that people were regularly engaged in meaningful activities. During this inspection, the activity coordinator was off and there were not many activities going on. Staff were completing tasks and did not have enough time to arrange meaningful activities for people.
- We observed most of the people were sitting in the lounge with the television or music on without any activities. It was not clear that the choice of programme or music was based on people's known likes and dislikes. Sitting in smaller circles would have encouraged more interactions between people and staff. At times some of the staff would initiate small ad hoc activities like listening to a story but it would not last long and people would be left on their own.
- People were supported to develop and maintain relationships with people that mattered to them. We observed relatives visiting people throughout our inspection.
- Staff did not help people with choices about how and where they wanted to spend their time. For example, there was one person sitting at the end of the lounge all morning. There was an entertainer session arranged for people. As they started singing and playing music loud, the person was still left right beside the singer. This person was there since the morning and no staff tried to check on the person or move them away from the loud music.
- There were records completed of staff engaging with people outside of performing tasks such as moving and handling or eating and drinking. However, activities were limited during our inspection.
- This meant people were still not protected from isolation and there was still a lack of stimulation for them. People were not always helped to maintain their emotional wellbeing or encouraged to participate in an activity suited to their needs.

The registered person did not ensure care and treatment was appropriate and reflected their preferences. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

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

- At our last inspection, we made a recommendation for the service to seek advice and guidance from a reputable source about meeting all five steps of the AIS to ensure all information presented is in a format people would be able to receive and understand.
- There were communication care plans in place, but the provider has failed to take action to ensure they

meet all 5 steps of the AIS.

- There was some guidance in communicating with people in a manner they could understand but it was not highlighted following AIS principles.
- Staff listed different ways of communicating with people, for example, using visual aids, simple questions and observing body language and giving time to respond. However, these approaches were not always followed in practice, particularly with those people living with dementia or whom displayed distressed behaviours.
- One person had a language barrier and the care plan noted how staff should support them by using a translating tool, the provider did not demonstrate they made reasonable adjustments under the Equality Act 2010 to make communication effective.
- Staff could use cards or body language to communicate with the person. Actions required included to provide picture cards, provide information in braille, document personal preferences in their personal goal section but this had not been documented. Records also noted "Speak clearly when asking questions and give time for the resident to form an answer" but this was not relevant to the person. It was not clear if an interpreter has been arranged for the person to make complex decisions.
- When speaking to 2 staff members, we observed the translator tool did not work as the person spoke too fast. A phone has now been purchased and a translator downloaded however most of the time, the staff signed to the person. However, during the time spent in the living room, there was very little communication and interaction between the person and any of the staff.

The registered person did not ensure care and treatment was appropriate, met people's needs and reflected their preferences. This was a continued 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 service had one complaint since the last inspection. There was a complaints policy in place. However, the complaint was not investigated according to the policy.
- There were some verbal complaints made and the relatives said these were addressed.
- The home manager explained how they dealt with complaints and that this was communicated to staff to ensure complaints were dealt with effectively.
- Most relatives knew how to raise a concern and would speak to staff or the home manager if they needed to.
- Most of the staff felt they could approach the registered manager with any concerns should they need to.

End of life care and support

- During our inspection, we were told one person was receiving end of life care. The home manager also said they were also slightly improving in their health.
- We reviewed care and support records for this person. Records were limited with information on how best to support the person. For example, the care plan for medicines support referred to pain medication and a pain chart. There was no evidence of a pain chart being used, no description in the person's care plan of what signs to look for if the person was experiencing pain.
- The medicines care plan also referred to specific medicines, but it was not prescribed on the MAR chart.
- The care plan did not specify how often the person should be repositioned; however, this was stated in the review note such as 2 hourly turn when lying on the right side and 1 hourly when lying on the left side.

Is the service well-led?

Our findings

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

At our last inspection we rated this key question inadequate. At this inspection the rating has remained 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

At our last inspection the provider had failed to notify the Commission of notifiable events, 'without delay'. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

- Services registered with the Care Quality Commission (CQC) are required to notify us of significant events and other incidents that happen in the service, without delay. This is important as it means we can check that appropriate action had been taken to ensure people are safe.
- During this inspection, we found the registered person had failed to notify CQC of a number of reportable events including allegations of abuse, a theft and one application outcome for a deprivation of liberty safeguard.

The registered person failed to notify the Commission of notifiable events, 'without delay'. This was a continued breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

At our last inspection the provider had not operated an effective system to enable them to assess, monitor and improve the quality and safety of the service provided.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- The provider did not evidence to us they had established more robust systems and processes after the last inspection so they could assess, monitor and mitigate any risks relating to the health, safety and welfare of people using the service, staff and the operation of the service.
- The provider's quality assurance systems did not identify concerns we found again during this inspection which are described throughout this report.
- The provider did not ensure they had a sufficiently improved oversight of the quality of care being provided, risk management and mitigation and staff practices, knowledge and competency to support people. This meant they were not able to demonstrate how they identified and worked on the areas where

improvements were needed.

- There was still little evidence the provider proactively looked at trends or themes in the incidents and accidents that occurred so that were able to identify areas of concern and take action to prevent reoccurrence and safeguard people.
- The provider gathered some feedback from relatives about the quality of care provided. However, we did not receive any further analysis and action plan from this survey to show how they used the feedback to develop the service and drive improvements.
- The provider did not ensure that accurate, complete and legible records were maintained or updated when necessary including records for people's care, decisions and seeking consent, and risk management.
- Information about people's care and support needs was kept in various places which made it difficult to ensure the care and support was being delivered in a consistent way and that information was available and accessible, for example, care plans, archived information, daily notes, nursing notes were all recorded and kept in different places.
- We were not assured good governance and oversight was always in place. There was insufficient evidence the provider has been more involved and checked on the day-to-day safety of people by involving themselves directly in people's and staff's daily routines.

The registered person had not operated an effective system to enable them to assess, monitor and improve the quality and safety of the service provided. They did not ensure there were established processes to ensure compliance with the fundamental standards (Regulations 8 to 20A). This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- We discussed with the home manager the duty of candour and what incidents were required to be notified to the Care Quality Commission. They understood some of the steps of the process, so we talked them through the requirements of the regulation.
- The provider had a policy that set out the actions staff should take in situations where the duty of candour would apply.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The home manager expressed a commitment to providing people with quality care and support and to instilling a culture where staff felt valued and promoted people's individuality. They understood more action was required to ensure there was 'a whole team' approach and a positive culture to be created in the service again.
- The home manager was receptive of our feedback and informed us after inspection some of the actions they had started to take to improve the service.
- Relatives were positive about the changes in the service. They said, "It is a lot better now since the new management. It is totally better on all accounts. Yes, it is easy to speak with [staff]", "It is all now going in the right direction and if they crack the weekend staffing issues, it will have succeeded on all fronts. Most of all the staff are really good", "It is better managed than what it was" and "We have a good relationship with the manager. I would not have any fears talking to [managers] about anything now".
- Professionals were positive about the changes in the service, as well. They said, "Recent change in [home manager] who demonstrates good leadership and strives to provide good quality care... There have been safeguarding concerns, quality of care concerns and staffing concerns but overall improvements are noticed", "The current manager appears to be engaging and motivated to improve standards... the current

manager is attending the online training that is on offer and prompting other team members to attend too. I find [the home manager] to be responsive and engaging... and does not appear to find it difficult to ask for help or advice and she appears to know the residents well" and "Since [the home manager] has been in post, the commissioning team have seen continued improvements in reporting, responsiveness, and a positive approach to meetings".

- We were aware the provider had been working with the local authority and other professionals with an improvement plan report being completed which detailed the issues and actions to be taken or that were already taken.
- Although we received feedback that the provider was engaging, the issues we identified during this inspection evidenced that they were still ongoing. We were not provided with enough evidence to show significant progress of the improvement plan. The lack of organisation and management of resources became evident throughout the inspection. Systems to monitor peoples' experience of care, management of staff skills and oversight of the quality did not appear to be effective or appropriate, and this led to issues remaining unresolved.

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

- The home manager spoke of ways and plans about how to help the service improve and changes needed. They felt supported by the provider and professionals working with them. We were unable to judge if this would be sustained at this time and the improvements would have to be reviewed at the next inspection.
- The home manager had started having staff meetings again and the team found them useful to be able to discuss various topics and share ideas.
- The provider informed us after inspection, that champions and key workers were recently appointed to oversee specific aspect of care to accelerate improvement.
- The home manager praised the staff team saying, "[The staff] are a very good team and they follow instructions. The staff want to learn and want to know more; they are easy to communicate with and they are willing to sit down and listen to you. They are a good team to work with, from admin to maintenance. I feel I am supported to make improvements".
- The home manager had also started having meetings for relatives/residents' meetings. They were welcomed positively. One relative added, "They are now doing family and relatives meetings and they are fabulous. It was wonderful".
- Other relatives said, "They listen now and act and want to know so they can sort issues like incidents", "Yes, I think so, [it is managed well]. They are open and want to hear from relatives" and "They do act on what I say. It is feeling its way as I would put it. It is getting there" and "I just hope it goes from strength to strength. 80% of everything is fantastic".
- The local authority and various professionals also worked with the service on an ongoing basis to support the management team to improve care and support provided to people. They kept us informed of their concerns about the service, as they completed their own checks on whether people received safe, effective and well-led care. The service engaged well with the local authority to work through the issues.

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 18 Registration Regulations 2009 Notifications of other incidents
Treatment of disease, disorder or injury	The registered person had not notified the Commission about specified incidents without delay. Regulation 18 (1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The registered person did not ensure care and treatment was appropriate, met people's needs and reflected their preferences in a consistent way. The registered person did not ensure the nutritional and hydration needs of service users were met in time, appropriate to their wellbeing and support was provided. Regulation 9 (1)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The registered person did not ensure the requirements about seeking consent were followed and in line with legislation and guidance. They did not keep complete and accurate records of consent and decisions made by people or on their behalf in their best interests. Regulation 11 (1)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	<p>The registered person did not ensure safe care and treatment. The registered person had not assessed the risk to health and safety of service users or done all that was reasonably practicable to mitigate any such risks. The management of medicine was not safe. The registered person did not ensure processes and systems in place were followed by all staff to meet their responsibilities in relation to preventing and controlling infection.</p> <p>Regulation 12 (1)(2)(a)(b)(g)(h)</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment
Treatment of disease, disorder or injury	<p>The registered person had not ensured that the established systems and processes to protect people from abuse and improper treatment were operated effectively.</p> <p>Regulation 13 (1)(2)(3)</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment
Treatment of disease, disorder or injury	<p>The registered person had failed to ensure the premises were suitable for people living with dementia.</p> <p>Regulation 15 (1)(c)(d)(e)(f)</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed
Treatment of disease, disorder or injury	The registered person had not followed their established recruitment procedures to ensure

the suitability of all staff employed. The registered provider had not ensured the information specified in Schedule 3 was available for each person employed.

Regulation 19 (1)(2)(3)(a) and Schedule 3

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Treatment of disease, disorder or injury	<p>The registered person did not ensure effective deployment of sufficient numbers of suitably qualified, competent, skilled and experienced staff to ensure they can meet people's care and treatment needs. The registered person had not ensured staff supporting people were appropriately trained and supervised in order to perform their work.</p> <p>Regulation 18 (1)(2)</p>

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 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	<p>The registered person had not operated an effective system to enable them to assess, monitor and improve the quality and safety of the service provided. They did not ensure there were established processes to ensure compliance with all the fundamental standards (Regulations 8 to 20A).</p> <p>Regulation 17 (1)(2)(a)(b)(c)(d)(e)(f)</p>

The enforcement action we took:

We have issued a warning notice to the provider for the failure of meeting regulation 17.