Care First Class (UK) Limited

Cherry Lodge

Inspection report

6 Manningford Road
Druids Heath
Birmingham
West Midlands
B14 5LD

Tel: 01214305986

Date of inspection visit:
08 November 2022
09 November 2022
15 November 2022
22 November 2022

Date of publication:
21 February 2023

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Cherry Lodge is a residential care home providing regulated activities of personal care and accommodation to up to 46 people. The service provides support to older people, people living with dementia and people with mental health needs. At the time of our inspection there were 45 people using the service. Cherry Lodge accommodates people in one adapted building. The home is set out over three floors with a passenger lift available to access the first and second floors of the home.

People's experience of using this service and what we found
People had not always had all of the risks associated with their care, fully mitigated. In some cases, risks had not been identified and where risks had been identified there was limited or incomplete guidance for staff to follow. People had not always received their prescribed creams. Records of cream administration had unexplained gaps in recordings.

Whilst relevant professionals were informed of incidents that had occurred there was no analysis of incidents across the service which may have identified themes and trends. In cases where learning had been taken from incidents, this learning was not always effectively implemented.

Systems around recruitment had not always been effective. We found risk assessments relating to staff members employment had not been put in place.

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

People were not always supported in a caring or empathic manner. Our observations showed task-based care practice where people were not routinely involved. There were missed opportunities for conversations between people and staff.

People had not been involved in planning or reviewing their care in line with their preferences. There were incomplete care records with little information of how a person may like to receive care. Activity provision was sparse, and people were not always consulted about the activities they were participating in.

The providers systems to monitor the quality and safety of the service were not effective. The inspection identified multiple shortfalls in care practice, the safety of care and in how people's rights were being upheld. The providers systems had failed to identify and address these concerns.

People were supported by staff who understood how to recognise and escalate safeguarding concerns should they have any. People received safe support with their daily medicines and checks were carried out on staff to ensure they were competent to administer medications.

People were supported to access appropriate healthcare and any concerns relating to changes in peoples' healthcare needs were escalated 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 requires improvement (published 24 April 2019).

Why we inspected
This inspection was prompted by a review of the information we held about this service. We undertook a focussed inspection to follow up on concerns we had identified following this review. During the inspection we identified further concerns relating to the care and support people were receiving so we widened the scope of the inspection to a comprehensive inspection reviewing all 5 key questions.

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.

Enforcement
We have identified breaches in relation to safe care and treatment, seeking people's consent, people receiving care that is centred on them and the governance systems in place to maintain oversight of the service.

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

Follow up
We will 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.

Special Measures
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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Cherry Lodge

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 two inspectors and an assistant inspector.

Service and service type
Cherry Lodge 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. Cherry Lodge 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. A manager had joined in May 2022 and informed us of their intention to apply to register as the manager of the service.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 08 November 2022 and ended on 22 November 2022. We visited the location on the 08, 09 and 15 November 2022.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We used information gathered as part of monitoring activity that took place on 06 September 2022 to help plan the inspection and inform our judgements. We sought feedback from the local authority. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to help us plan the inspection.

During the inspection
We spoke with 5 relatives and 2 people who use the service. We spoke with 2 professionals involved in people's care at the service. We spoke with 7 staff including care staff, the chef and activities coordinator. We also spoke with the manager, quality and compliance officer and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed 10 people's care plans and associated documentation. We viewed 5 medication records. We viewed 5 staff recruitment files to see how staff were recruited. We reviewed information relating to staff training and documents relating to how the service was monitored.

Inadequate

Is the service safe?

Our findings

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

At our last inspection in November 2020, we reviewed the infection control measures in place, but we did not award a rating. At our inspection in February and March 2019, we rated this key question as Requires Improvement. At this inspection the rating has changed to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Using medicines safely

- People were not always supported to receive safe care. For example, one person's care record stated they required food to be prepared to a modified texture. We saw the person was served food that had not been safely prepared. We immediately flagged this with the manager, who took the person's meal away as it presented a risk to them. The manager and staff gave varying answers as to how the person's meals should be safely prepared. This risk had not been properly assessed and there was no clear and consistent guidance about this.
- We observed one person who appeared to be significantly underweight. Staff told us this person had lost weight since joining the service. Records showed the person had refused multiple meals the week before the inspection, but this risk had not been identified or acted on. Oversight of the person's weight was poor as weight records were inaccurate. The lack of action left the person at risk of not receiving adequate nutrition.
- We saw one person's floor sensor mat had been unplugged and stored under their bed, which meant their only means of seeking staff support was to shout until they were heard. This person was at risk of falls. The measures in place to alert staff when this person was mobilising were ineffective which placed the person at increased risk of harm. We needed to prompt staff to support this person and for the nominated individual to review their use of sensor mats at the home.
- Risks in the environment had not always been adequately mitigated. We saw there was an open sharps box in the main office where people living at the home could access it and cause potential injury. A sharps box is a device whereby used medical equipment such as needles are disposed of. Staff were not always available in the office area and we had to prompt the management team to remove this hazard.
- We saw that disposable gloves had been left in easy access of people living at the home in an areas where staff were not routinely available. The easy access of the gloves placed people at potential risk of ingesting a glove. We raised this concern with the manager and nominated individual who agreed this was a risk. The potential risk of harm to people had not been adequately mitigated.
- Medicines records in relation to people's prescribed creams were not accurately completed. For example, multiple records were left blank and it was unclear whether people had prescribed creams applied. This placed people at potential risk of developing sore skin.
- We saw that staff who were leading the medicines rounds, were interrupted on a number of occasions for example, to answer the door, the phone or being asked for help by colleagues. This failed to promote safe practice to ensure people would always receive their medicines safely and as prescribed.

The provider had failed to ensure safe care and treatment was being provided to people. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

● Systems to monitor staff practice following manual handling training required further improvement as some poor practice had not been identified by the manager. We saw that staff did not always apply the brakes on people's wheelchairs whilst supporting people to move using a hoist. This did not promote people's safety, as the wheelchair could start to roll away while the person was moved towards or away from it.
● People were supported by staff who had received training around medicines management and who had had their competency checked to ensure medicines were given safely.
● People had their daily medicines administered safely.

Preventing and controlling infection
● We were somewhat assured that the provider was preventing visitors from catching and spreading infections. The provider had not ensured effective systems were in place to check visitors health status. Visitors were not asked whether they had any COVID-19 symptoms or to have their temperature checked on entering the building though we saw visitors wore PPE.
● We were somewhat assured that the provider was supporting people living at the service to minimise the spread of infection. We saw the nominated individual, manager and quality and compliance officer all wore excess jewellery and/or nail varnish which did not lead by example and did not adhere to good infection control standards.
● We were somewhat assured that the provider was using PPE effectively and safely. Most staff wore face masks, however, some, including the nominated individual and manager, wore face masks underneath their noses which meant it wasn't used effectively nor followed guidance in place at the time of the inspection.
● We were somewhat assured that the provider's infection prevention and control policy was up to date. The policy did not contain up to date guidance and there was no recorded guidance on carrying out risk assessments for those people who may be at higher risk of contracting COVID-19.

We found no evidence people had been harmed however, the provider had not taken all reasonable steps to protect people from the risk of infections. 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 admitting people safely to the service.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises. We saw there were designated cleaning staff throughout our inspection visits.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

We have also signposted the provider to resources to develop their approach.

Visiting in care homes
● Relatives told us that they could visit the home whenever they liked. A relative told us, "I can attend whenever I want. [There are] no restrictions." People had needed permission to have visitors, during the COVID-19 pandemic to reduce risks to themselves and others.

Staffing and recruitment
● Staff had not always been safely recruited. We identified recruitment checks had not always been carried out safely, and some records lacked details such as staff members' full employment histories and

recruitment decisions.
● We saw two staff members, recruited in 2016 and 2022, only had DBS checks on their records that were completed by their previous employers. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. Despite these records showing both staff members had criminal convictions recorded on their DBS the provider had failed to carry out their own DBS checks, or any risk assessments in relation to these criminal convictions. This failed to protect people in their care as far as possible.

The provider had not ensured robust recruitment practices were in place. This was a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Appropriate checks had been carried out for an agency staff member, for example confirming their COVID-19 vaccination status and a clear DBS check. A staff member who had started in May 2022 had completed DBS and reference checks.
● There were sufficient staffing levels on each shift. People were regularly supported by agency staff. One person told us, "Some of the agency staff that come are alright, it dips [with agency staff in relation to the quality of care], or you may have someone [providing care well] and then never see them again." A relative told us, "There's different staff. We don't know if they're agency. We can't get to know them." The relative also commented that there were some permanent staff who supported their loved one very well.
● The provider told us they were having ongoing difficulties with recruiting permanent staff and as such consistent agency staff were being used regularly at the service.

Learning lessons when things go wrong
● Incidents were not properly analysed and reviewed to promote people's safety as far as possible. For example, an incident record showed one person had made inappropriate sexual contact towards another person. It stated this person should not be left unattended, to reduce the risk of this happening again. Although this analysis had been carried out, we saw the person was left unattended. When we asked the nominated individual and manager how they were managing risks related to this incident, we identified they were unaware of this incident. The providers systems had not ensured learning from incidents was embedded into practice to ensure the safety of the people living at the home.
● Incident records showed action was taken to keep people safe immediately after incidents, for example, to report safeguarding risks to the local authority or to seek medical attention. However, audits of incident records only listed a brief summary of incidents, when they had occurred and whether the local authority and CQC had been informed. This did not include sufficient analysis to identify themes from incidents and to ensure that all relevant action and learning had been taken to reduce the chance a reoccurrence.

Systems and processes to safeguard people from the risk of abuse
● Whilst people received support from staff who understood how to safeguard people, communication systems around safeguarding could be improved. On the first day of our inspection, we observed an altercation between two people living at the home. Staff had not informed the manager of the altercation. ● We informed the manager of the incident and prompted them to raise the concerns with the safeguarding local authority. On the second day of the inspection the manager had not raised this safeguarding alert, therefore we raised this safeguarding with the local authority.
● Staff were aware of the correct processes to follow in relation to safeguarding people living at the home. They could inform us about the signs they would look out for that may indicate that a person had experienced abuse.
● Where safeguarding concerns had been identified the manager had notified the appropriate authorities

for investigation.

- A person living at the home told us they felt safe.

Requires Improvement

Is the service effective?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has remains the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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.

● People were unlawfully restricted and there was a blanket restriction across the home, preventing all people from going out. One person told us, "You can't go out unless you've got your relations with you… You couldn't just go out to the shops, no, I wish I could." Another person told us it was the 'rules' that they could not go out as and when they wished. Both people's records stated they had capacity and there was no recorded reason as to why they should be prevented from going out independently and have their liberty restricted in this way.
● Nobody living at the home was made aware of the key codes that allowed their entrance to and exit from the home. The nominated individual told us they would not share the key codes with people living at the home, "Because they'll share them out and other people will want to go out". This was risk averse and restrictive practice, which was applied to everybody living at the home.
● Where the nominated individual expressed doubts about people's safety to go out independently, there was no evidence that any risk assessments had been carried out, to balance people's independence and safety. We were concerned that the nominated individual lacked understanding around the principles of the Mental Capacity Act (2005).
● We saw multiple interactions where people were told by staff what support they were going to receive, but people were not asked if they wanted this to happen. People's consent was not routinely sought before care was provided. For example, one person's nose was wiped by a staff member without the person being asked if they wanted this to happen, and they were not given a tissue and encouraged to do this independently if

they wished.
● The service had CCTV in use in communal areas of the home. The nominated individual told us this was to help review incidents. People had not been consulted with to ensure they consented to the use of CCTV in their home and there were no capacity assessments for those who could not consent.
● Where specific decisions had been made about some people's care, the relevant records such as mental capacity assessments and best interests decisions were not available to demonstrate the principles of the MCA were always followed.

People had not been appropriately supported under the Mental Capacity Act (2005). This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● A relative informed us that staff supported their loved one to make choices in their care, "They will always ask her and will always give her a choice, if it is about food or anything like that, they will ask her first as far as I am aware anyway."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● We saw people's care needs had not always been assessed to establish what their risks were. There were areas of care records that had not been completed.
● Where risks had been identified sufficient guidance was not always in place around the support the person needed as a result. For example, where people were at risk of not receiving adequate nutrition.
● Care records had not always been updated or reviewed in the timescale specified by the providers care planning system.

Staff support: induction, training, skills and experience
● People were not always supported by staff who had received all the required training for their role. The provider had three separate systems to monitor staff training. Our review of these systems indicated that not all staff had received training relevant to their role. This included training around mental health, dementia awareness, fire safety and safeguarding adults. This put people at potential risk of receiving unsafe care.
● For those staff who had received training we found they could describe how their training related to the people they supported. Staff we spoke with said they had received sufficient training for their role and that the training provided supported them to understand people's needs.

Supporting people to eat and drink enough to maintain a balanced diet
● People had not always been supported to have their food prepared safely or have their nutrition and hydration sufficiently monitored. This placed people at potential risk of poor or unsafe nutritional intake.
● People we spoke with told us the food was 'Alright,' and 'Fine'. A relative we spoke with informed us, "The food must be good otherwise mum would not eat it."
● The chef informed us that they sought people's preferences for meals when they first moved into the home. The chef planned menu's for people around these preferences. A pictorial menu board was on display in the dining room to aid people's understanding of the meals that were available on that day.
● We noted that the mealtime experience for people could be improved. Some people chose not to eat in the main dining area, preferring to receive their meals in the communal lounge. People who sat in the communal lounge received meals on low rise tables that they had to bend down to reach. This did not facilitate a pleasant meal experience or maximise the opportunity people had to receive good nutrition.

Staff working with other agencies to provide consistent, effective, timely care
● People were supported to access support from other agencies. One person's records showed the service

had contacted health professionals on their behalf when they were unwell. However, no care assessments had been completed in the interim to help identify and assess the person's needs and contact with additional professionals had not been considered to meet this person's other additional needs.

● District nurses regularly visited the home to support people with their diabetes management and wound care. A visiting professional commented, "Generally I've got no concerns at all. It seems to be a lot better managed under this new manager than before as we had quite a few concerns before. Everything seems to have settled down. As soon as there's a problem with anyone's skin, they ring us and ask us to come in."

● We saw emergency services were contacted when one person became very unwell during the inspection.

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

● Parts of the home had been decorated in line with current good practice around dementia care to engage people. However, this was not used effectively in practice. For example, a bus stop sign had a bookcase stored underneath it which covered up this decoration. In another example, a sign displayed what day it was and what the weather was like, however we saw this was two days out of date which would disorientate, rather than inform people.

● Some people's bedrooms had memory box decorations and photographs at their bedroom door entry to help navigate and welcome them.

● We saw there were railings fitted throughout the home to support people to safely move around and people had easy access to walking frames as needed. There was a lift to the upper floors of the home to enable people to access their bedrooms independently should they so wish.

Supporting people to live healthier lives, access healthcare services and support

● People were supported to access healthcare as needed. A relative told us, "They phone me and keep me up to date if anything [happens]", and confirmed the home had sought healthcare support when the person had been unwell recently.

● The manager informed us that the local general practitioner carried out a weekly visit to the home. This enabled any concerns about people's health and well-being to be escalated to appropriate health professionals.

Inadequate

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 good. At this inspection the rating has changed to Inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

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

- Our observations between some staff and people demonstrated that people were not consistently supported in a caring or empathic manner. We saw numerous occasions where staff had missed the opportunity to communicate with people. For example, staff would support a person with a task and then leave the room. On other occasions, communication occurred between staff members about a person but the person was not included in the communication about their care.
- We saw an altercation between two people living at the home. Staff and a relative told us this occasionally happened between people using the service. The provider had not reviewed the culture of the service to enable positive relationships between people living at the home.
- Staff had not always had due regard to considerations around people's well- being. On one occasion, one person placed their head on the dining table but none of the staff members in the same room intervened to check if the person was comfortable and well. In another example, we saw one person standing in the hallway who looked upset. The nominated individual informed us this person lived with anxiety. A review of the persons records gave instruction for staff to sit and talk with this person if they were anxious. This guidance had not been followed.
- We saw one person had told staff that they wanted to get up from their chair in the lounge. The person walked with a zimmer frame and needed staff with them. We saw staff tell the person repeatedly to 'sit down' when they wanted to walk with purpose.
- We were told that people had sensor mats in their rooms, which was their means of calling for staff assistance from their bedrooms. The nominated individual told us call buzzers were available but had not been used. This did not promote people's dignity and independence, for example, they had to get up from bed and/or move towards the sensor mat in their rooms, if they needed support.
- Peoples confidentiality was not being maintained. For example, we observed medicines records left open and accessible on top of the medicines trolley. Conversations also took place with people in corridors rather than staff ensuring a quiet and confidential room was found to have a private discussion about their care. This failed to maintain confidentiality in relation to people's care and support.

People were not consistently supported to receive support in a caring and dignified manner and have their privacy respected. This was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We saw the service had received thank you notes and cards from relatives, thanking staff for their

compassionate and caring approach and for looking after their loved ones.
● We saw people were dressed comfortably and well presented.
● Staff told us how they preserved people's dignity whilst providing personal care. This included placing a towel over people whilst they had a wash.

Supporting people to express their views and be involved in making decisions about their care
● Throughout our inspection, we saw people received task-based care which failed to promote people's choice, control and involvement in their care. People were only approached to be told what was happening next, for example, 'We're going to move you now', through moving and handling support, and they were not asked beforehand if they wanted to move. Once one person was supported, we saw staff moved on to the next person and approached them in a similar way.
● Opportunities were not taken to involve people in the running of the home. The home newsletter had not been maintained in recent months and there had only been three records of residents' meetings over the course of 10 months where people might have been encouraged to give their views and opinions. A relative also confirmed people and relatives were not asked for their views on their care.

Inadequate

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 Good. At this inspection the rating has changed to Inadequate. This meant services were not planned or delivered in ways that met people's needs.

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

- People and their loved ones were not invited to take part in care assessments or reviews by the provider. Records we sampled confirmed a lack of people's 'voice', views and decisions about their care. This failed to ensure people's individual needs and wishes for their care were known and met. A relative told us, '[We're] not asked about interests, music, what [person] likes.'
- The nominated individual and manager recognised that care planning processes were not adequate and that care planning records were incomplete and had not included people or their families. For example, there were no care plans for people living with dementia to identify and inform staff of people's needs associated with dementia.
- Where care plans had been completed, they were not reviewed in the timescales set out on the electronic care planning system. One person who had a planned care plan review date of 18 May 2022 had not had their care plan reviewed. Additionally, these care plans were reviewed by care staff and we did not see that care plans were reviewed with people and/or their relatives.
- Staff did not always demonstrate a clear awareness of their role to provide person-centred care. One staff member told us, "Trouble is, [person] has a mind of their own and you'll argue and anything you try and tell [person], they'll make an argument of… you've got to do it their way or no way. No, it's not unreasonable but it's time consuming… you're thinking what other jobs you could be doing." A comprehensive assessment of the persons needs had not been carried out to ensure staff had a clear understanding of their needs and wishes. Advocacy support had also not been considered for the person.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People had not always been supported to access activities of interest or receive care based on their preferences. We found care records had not included reference to people's interests or hobbies.
- During our inspection, we saw most people living at the home spent the majority of their day seated in communal areas. A professional who visited regularly told us, "This is what you see… sat in a room with the television on and music on." People were not approached or interacted with beyond task-based support.
- We observed that people were not always asked if they wanted to take part in the activity offered to them. People had been given pictures to colour in without determining if this would be an activity they would enjoy. No one was given anything to lean on and a person fell asleep during the activity.
- A person told us, "There is nothing in the way of activity here." One relative felt there could be improvement in the frequency of activities at the home and told us, "Could improve with more activities to do."

People had not been involved in planning or reviewing their care or received care that was based on their preferences. This was a breach of Regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● A relative told us, and records we saw showed, that festive calendar events were celebrated.
● One person told us, "Usually activities wise there's a lady in here, we usually do artwork or something she finds in the cupboard or we watch a film. There's going to be a raffle. She's ever so good." We saw some people regularly met with or went out with their relatives
● The activities coordinator informed us that they sought peoples' preferences for activities verbally but that at times it was difficult to carry out activities due to other staff resources needed. There were no planned activities for the week and they took place on a more ad-hoc basis.

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.
● Staff were aware of one person's communication needs in relation to their visual and hearing impairment. However, improvements were needed in providing additional guidance for staff in line with this standard, for example, to ensure the person always received information in an accessible format.
● We saw one person's care plan had been translated into their first language as they did not speak fluent English.

Improving care quality in response to complaints or concerns
● Most relatives told us they knew how to raise a complaint but that they had not needed to. Relatives told us they approached the manager with any concerns they had and that the manager resolved this. One complaint record we sampled showed the complainant had been apologised to and reasonable steps had been taken to respond to their concerns.
● A complaints log referred to 3 complaints which had been received. The log detailed the outcome of these complaints but did not specify how this had helped improve the quality of care or how complainants or other people and relatives had been communicated with in light of these concerns.
● One person had complained in January 2022 about not being able to go out and we saw they had escalated their concerns to the local MP and local authority. The management team had told the local authority, that this person had recently gone out shopping. This was not an adequate response to the person's complaint about going out overall as they wished. The theme of this complaint was identified as a concern at this inspection. The complaints process had not been used, on this occasion, to drive improvement in the service as far as possible.

End of life care and support
● Some of the staff team had received training around end of life care. One person's end of life care plan we sampled contained basic information and a note had been added to the system that this care plan needed a review. The nominated individual and manager confirmed they intended to review and improve the quality of people's end of life care plans.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question Requires Improvement. At this inspection the rating 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; Continuous learning and improving care

- The provider had failed to establish and operate effective quality assurance systems to assess and monitor the safety and quality of people's care. Audits were not robust and failed to adequately identify and address shortfalls in the safety of the service, including, but not limited to, medicines management, care planning and risk management, staff training and recruitment practices.
- Records were not accurately maintained and we found numerous examples where basic care plans were missing. The nominated individual and manager were aware this was a priority improvement for the service.
- Systems to ensure accurate records were available in relation to the support people needed in the event of a fire were not effective. Information about people's care needs in the fire safety grab bags was inaccurate and had not been updated to include new residents. The provider had failed to maintain accurate records in relation to people's support needs in the event of a fire which placed people at potential risk of harm.
- Systems to monitor the DoLS process were not effective. There was incorrect and incomplete information on the system which meant applications for DoLS and approval of DoLS could not be monitored effectively.
- The provider had not implemented effective systems to monitor infection control practice. We observed face masks were not always worn effectively and systems had not been introduced to monitor the health status of visitors. In addition, the provider had not ensured the infection control policy provided up to date guidance to the staff team.
- The provider had failed to ensure robust systems were in place to continuously learn and improve care for people. Incidents had not been analysed or reviewed to identify themes and trends or additional learning to prevent reoccurrence. In addition, complaints received had not been used as a means of learning and improving care for people.
- There were ineffective systems in place to make and sustain improvements in the service. The provider has been awarded repeat overall 'Requires improvement' ratings since the first ratings inspection of this location in September 2015.

Systems were not robust enough to demonstrate effective monitoring of the quality and safety of the service. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The location has had three managers over the last 12 months. The current manager had joined in May 2022 and informed us of their intention to register as the manager of the service.
- Staff felt supported in their roles and one staff member informed us the current manager, "Is a really good

manager. She is the best one. She is professional and knows what she is doing."
● A quality and compliance officer had joined on the week of our inspection for two days per week, to support improvements to the service. They carried out a medicines audit which was completed across the provider's other two services. This audit had identified that further improvement was needed with the recording of prescribed creams.
● Whilst the nominated individual, quality and compliance officer and manager acknowledged the concerns we identified during our inspection and expressed their intentions to drive improvements at the service, they had not established their priorities or an action plan to do so effectively.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The provider had a poor understanding of the requirements of the Mental Capacity Act (2005) and people were supported in a restrictive, risk-averse culture which did not promote their choices and control over their care.
● There were limited means of gathering people's feedback and views on their care, or to involve people in discussions to help inform care that was centred around people's needs.
● The management team had not always led by example to promote a positive person centred culture to enable people to receive compassionate, effective care.
● One relative informed us that the staff team had got to know their loved one well and said, "Yes, attentive, always watching. Overall, friendly not shouting or nastiness." Another relative told us the staff were, "Very friendly, helpful." Another relative informed us, "I am very happy, my sister is happy, we are happy as a family. Happy with the care."
● One staff member informed us that the best part of their role was, "the support we give to each other and the residents." Another staff member informed us, "I do enjoy it and coming to work and my duty of care is looking after the residents and that's what I like."

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
● Some improvement was needed to ensure people were fully informed of the outcome of incidents under duty of candour. In April 2022, one person had been given excess dosage of their medicines for 17 days. Although the provider had notified CQC and the local authority as required of this medicines error, our conversation with the person's relative confirmed the provider had not fully acted on the duty of candour which included providing a written response and apology.
● The manager and nominated individual had been open throughout the inspection process and facilitated our requests for information.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The manager recognised there were no formal means of gathering people's feedback and regularly engaging with people and relatives at the time of the inspection.
● The manager told us they had put a comments and compliments book in the reception area to start to address this. We saw some visiting relatives had used this to give positive feedback about their care. A relative told us, "A couple of weeks ago, the deputy manager brought me a book to say about comments at the door. I added a quick note in there."
● The manager was in the process of sending out surveys to relatives to gather feedback about people's care.
● Staff told us they felt supported in their roles and able to make suggestions for improvements.
● A relative informed us that they felt involved in their loved ones care and told us, "They listen and get in

touch if anything is wrong. They keep me up to date." When asked if the service asked for their views of care one relative said, "They have not asked for my opinion for the service. I feel I can express anything I need to."

Working in partnership with others

- The manager and staff worked with other health professionals to escalate concerns and ensure people received appropriate support that enabled good health and well-being.

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 10 HSCA RA Regulations 2014 Dignity and respect The provider had failed to ensure people were consistently supported with dignity and respect and had their privacy respected. Regulation 10(1)(2)(a)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to ensure robust recruitment procedures were in place. Regulation 19 (2).