Maples Care Home (Bexleyheath) Limited

# Maples Care Home

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

About the service
Maples Care Home is a care home set over three floors and provides residential, nursing and dementia care and support for up to 75 older people. At the time of our inspection, 61 people were using the service.

People's experience of using this service and what we found
Risks were not always assessed, identified and/or updated and risk management plans were not always in place to manage risks safely. Records were not always completed and monitored in line with people's individual needs. Medicines were not always safely managed. Staff were not always available when needed. Accidents and incidents were not analysed and learning from this was not disseminated to staff.

People were not always supported to eat and drink when required. Staff training was not up to date, with no training provided for Epilepsy. Supervisions and appraisals were not carried out in line with the provider's supervision policy. People's privacy and dignity was not always respected. People were supported to have maximum choice and control of their lives. People's needs were not always met by the design and decoration of the home. We have made a recommendation about sourcing designs and decoration that would be conducive to people who live with dementia.

People and/or their relatives were not always involved in planning their care needs. Complaints were not managed in line with the provider's complaints policy. People's communication needs were not always met. People's end of life wishes, were not always documented. There was a lack of activities on offer to stimulate people. Systems in place were not effective to assess and monitor the quality of the service provided. Feedback was sought from people, their relatives and staff to improve on the quality of the service provided.

Assessments were carried out prior to people joining the service to ensure their needs could be met. People were protected from the risk of infection. The service worked in partnership with key organisations and health and social care professionals when required.

Rating at last inspection and update
The last rating for this service was Good (published 23 December 2020). At this inspection we found the provider was in breach of regulations.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection. The overall rating for the service has changed from Good to Inadequate. This is based on the findings at this inspection.

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

service can respond to COVID-19 and other infection outbreaks effectively.

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

Enforcement
We have identified breaches in relation to safe care and treatment, staffing, person-centred care, dignity and good governance at this inspection. Please see the action we have told the provider to take at the end of this report.

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

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

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

## The five questions we ask about services and what we found

We always ask the following five questions of services.

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

# Maples Care Home

**Detailed findings**

## Background to this inspection

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

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 team on the first day consisted of 3 inspectors. One inspector returned to the service on the 2nd and 3rd day and an Expert by Experience made telephone calls to relatives to gather their views about the service. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Maples Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. [Care home name] is a care home [with/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 a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
Before the inspection, we reviewed information we held about the service since our last inspection. The provider was asked to complete a provider information return (PIR). The PIR 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 plan our inspection.

During the inspection
We spoke with 2 people and 4 relative face to face. We also spoke with 16 relatives on the telephone about their experience of the care provided. We spoke with 12 members of staff including the registered manager, the clinical manager, nurses, medical technicians, care workers, activities coordinator, kitchen, and house-keeping staff. 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 express their views about their care to us.

We reviewed a range of records. This included 10 people's care records and multiple medication records. We looked at 4 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We continued looking at care plans and risk management plans, as well as quality assurance records.

Inadequate

# Is the service safe?

## Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated, to Inadequate. This meant people were not always safe and protected from avoidable harm.

• People were not protected from harm. Risks to people had not always been identified and assessed. Risks were not regularly reviewed to ensure people's needs were safely met. This included risks, associated with, falls, choking, epilepsy, asthma, diabetes, nutrition, medicines, call bells, mobility, communication and absconding.
• Where risks were identified, appropriate risk management plans were not in place to guide staff on how to safely manage these risks and minimise or prevent them from happening. For example, risk assessments for people living with diabetes, did not include guidance on the acceptable range of hyperglycaemia or hypoglycaemia (high or low blood sugar).

• There was not always clear information and guidance for staff about specific medical conditions people had, for example, epilepsy. There was no epilepsy protocol or guidance in place for staff on what they should do if a person had a seizure. For example, one person's epilepsy risk assessment, stated in the event of a seizure, staff should administer first aid – but did not detail what this included. There were also no seizure recording forms in place, so that staff could document and analyse the seizures for themes or triggers.
• One person's care plan documented that they slept a lot during the day. During the inspection we saw this person was hunched over to one side in an armchair asleep in a communal hallway. Although they were asleep, staff were attempting to support them to eat their lunch. This was a choking risk as the person was not alert and sitting upright. Other staff in the vicinity did not identify this as a risk, we also found the person had no choking risk assessment in place.
• We saw that another person's nutrition care plan showed that they were on a normal diet and did not have swallowing difficulties but was dependent on staff support to eat and drink. However, the care plan failed to clearly identify that this person was at risk of choking. This person had seen a speech and language therapist (SALT) in March 2023 and there were specific instructions in place for staff to follow. This included ensuring that the person was sat at a 90-degree angle and was well supported by pillows. During lunch this person was not being supported by pillows to keep them upright. We observed staff starting to support this person to eat but then leaving them to assist other people. Failure to support the person with pillows and to sufficiently eat and drink placed this person at risk of choking and harm.
• Positioning charts demonstrated that people were not always repositioned frequently in line with information their care plans, for example, one person was not repositioned every 2 hours, whilst another person was not repositioned every 4 hours as required. Repositioning charts for both people showed that they were not always repositioned on to a different side of their body to reduce the risk of skin damage. Repositioning charts were not regularly monitored and analysed to identify this poor practice.
• One person lived with asthma, although the risk had been assessed, there was no clear guidance for staff to follow should the person have an asthma attack.

• People who were at risk of absconding did not have risk assessments in place or risk management plans to guide staff on the distraction techniques to use and to reassure people.

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

• Following the inspection, the provider confirmed that all risk assessments and care plans will be updated by the end of September 2023 and also sent us an action plan. We will check this at our next inspection.

• People had Personal Emergency Evacuation Plans (PEEPS) in place, these were person-centred and detailed how individuals, would safely be evacuated from the home in the event of an emergency.

Lessons were learnt from accidents and incidents to improve the quality of the service.
• Lessons were not always learned. Records showed that accidents and incidents were logged monthly. However, effective systems were not in place or robust enough to demonstrate incidents were effectively monitored, analysed and reviewed. Follow up actions taken to protect people in the future were not always documented.
• Audits relating to accidents and incidents were completed. However, the findings were not used to improve quality and safety for people. For example, in the audit for April 2023, there was an incident recorded where, one-person mixed shampoo into their porridge and ate it. The person's care plan documented that shampoo should be removed from the person's room when not in use. However, during the inspection we found that there was a bottle of shampoo left in their bathroom.

• There were no records to show that learning from accidents and incidents had been disseminated to staff to learn from. This meant people were placed at risk of on-going harm.
• Our inspection findings showed that the quality and safety of the service has significantly deteriorated since our last inspection.

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

Following the inspection, the provider had actioned learning from this, in that they told us that they had installed lockable cupboards in people's rooms to ensure topical creams were securely stored. We will check this at our next inspection.

Using medicines safely
• Medicines were not always safely stored or managed appropriately, this placed people at risk of harm.
• On the first day of this inspection, we saw that people who were administered prescribed creams did not always have body maps in place and reported this to the registered manager and the clinical lead. Following first day of inspection the clinical lead confirmed body maps were kept in a folder at the nurses' desk on each floor. However, body maps we reviewed did not have dates on them, so, we were not assured they were up to date.

• During the inspection, we found that prescribed topical creams were left in people's room on sideboards or bathrooms. There provider did not have secure cabinets that these could be locked away in people's rooms. When staff were made aware of this – the creams were all collected and stored in the nurses' room on top of a filing cabinet. However, because the topical creams were largely the same for service users, they were not then able to distinguish which cream belonged to who as a lot of the prescription labels had been worn

away. This put people at risk of receiving the other people's medication.

• We found there were no fire risk assessments in place for people using flammable topical creams.

• Guidance for staff administering medicines was not always clear. Information in care plans did not always match what was on the Medicine Administration Records (MAR), such as strengths and formulations of medicines.
• Some instructions about how medicines should be given did not always match what had been agreed on the assessment. For example, 1 person's assessment said to crush and mix medicines with water and their care plan said to mix in yoghurt.
• We saw that only 45% of staff had received up to date medicines training. Medicine competency for all staff had not been carried out to ensure that they were/remained competent to administer medicines safely. We saw that only 23% of staff were assessed as competent to administer medicines.
• We saw controlled drug patches were not always disposed safely.

• Quality assurance processes had failed to effectively identify and address the issues identified during this inspection. Systems in place had failed to ensure medicines were always safely managed.

Poor medicines management put people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Following the inspection, the provider told us that they had installed lockable cabinets in people's rooms to securely store topical creams.

Staffing and recruitment
• Staff were not always available to support people's needs in a timely manner. The registered manager did not have oversight of staff around the home.
• Feedback from relatives was that there were not enough staff visible, and relatives had to search for them if people needed support. One relative told us, "There are not enough staff, we always have to go looking for staff. After 7pm the place is deserted, some nights there are only two staff to look after 15 people." Another relative said, "We have had issues which I have reported, I go at the weekends and evenings and have seen 12-14 residents and no carer. I find it difficult to find out who is in charge, it is the nurse but sometimes she is called away. A 3rd relative said, "Sometimes there aren't enough staff in the lounge." A 4th relative said, "I would like to see more staff on the floor…… I feel the staff are stretched."
• During the inspection, we frequently saw that the lounges on each floor at different times of the day, did not have at least one staff member to support people should they need it. We also observed that although lunch was scheduled for 1.30pm, we saw that some people were still waiting to be served their lunch at 1.55pm.
• On the 3rd day of inspection, we saw that on the ground floor dining room there were only 2 staff members supporting 16 people at lunch time. People who required support to eat and drink did not always receive this support when their meal was served to them. This was because the 2 members of staff on duty were either plating meals and pouring drinks or serving them to other people.

• Where people did require support to eat and drink, there was not a dedicated member of staff to do this, we saw staff supporting more than 1 person at a time to eat and drink. So, people were left for periods of time before a staff member could return to them. We saw some people at fallen asleep waiting for staff to support them with their meal.
• The registered manager told us that call bells should be answered within 3 minutes. However, we observed call bells were not always answered in a timely manner. During the inspection we saw that a call bell had

gone unanswered for over 5 minutes and an inspector had to draw staff's attention to it. We reviewed call bell audits and saw that one person had to wait 13 minutes. One of the outcomes of the audit was, that staff had to be reminded of the need to respond to call bells. However, during this inspection we found that this shortfall had not been addressed.

This was a breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection, the provider confirmed that they would review how staff were deployed throughout the home. We will check this at our next inspection.

• The service had safe recruitment practices in place. The service carried out checks to ensure there were no gaps in education and employment histories. Employment references were obtained, and appropriate Disclosure and Barring Service (DBS) checks had been carried out. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. This information helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse
• People were protected from the risk of abuse but feedback from some relatives showed they were concerned with their care. We received mixed feedback from relatives. One relative told us, "My [family member] fell out of bed and we don't know if the sides were put up on the bed. Another relative said, "My [family member] isn't getting help to eat. I am telling [staff] this all the time but it isn't being communicated to people who can change things

• Positive feedback included, "Yes my [family member]is safe." Another relative said, "[My family member] is safe living there, much safer than living at home."
• There were up to date safeguarding and whistleblowing policies and procedures in place.
• The registered manager and other management staff understood their responsibility to protect people in their care from harm and to report any concerns of abuse to the local authority safeguarding team and CQC.

Visiting in care homes
• Relatives we spoke with told us that they were that they were able to visit people at the home without restriction.

Preventing and controlling infection
• 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 promoting safety through the layout and hygiene practices of the premises.
• We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
• We were assured that the provider's infection prevention and control policy was up to date.

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 the last inspection this key question was rated as requires Good. At this inspection this key question has deteriorated to Requires Improvement. This meant people's outcomes were not consistently good.

Staff support: induction, training, skills and experience
• Nine relatives we spoke with told us that staff were not well trained. One relative said, "Some of the carers are not well trained, but it is also a language thing." Another relative said, "Some [staff] are definitely not skilled. Staff hang around waiting to be told that to do. There is no-one assigned to them." A 3rd relative said, "Some agency staff don't have the skills needed….. they could be vetted more." A 4th relative said, "Some [staff] are not skilled in dementia…manual handling training could be better."

• Records showed that not all staff had received refresher training in medicines, safeguarding, moving and handling, dementia, infection control, dementia and mental capacity. There were no records to show that any staff received training in epilepsy and diabetes."
• The registered manager told us, that on an annual basis staff received 3 supervisions and 1 appraisal in line with their policy. However, records showed that not all staff had been supported to have at least 3 supervisions annually. This meant the provider could not be assured that staff performance was effective.

The provider failed to ensure staff were appropriately trained and competent. Staff did not always receive suitable support. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Following the inspection, the provider told us that there was no frequency of staff supervision throughout a year. The provider's data suggest that 8 staff have had no supervision at all in 2023.

Supporting people to eat and drink enough to maintain a balanced diet
• People were not always supported to eat meals and drink enough amounts for their health and wellbeing. Where people needed encouragement to eat, they did not always have their food likes and dislikes documented in their care plans. This meant that staff were not aware of people's preferences and the types of food people could be tempted with.

• Where people were at risk of malnutrition and dehydration, there was a lack of oversight of people's food and fluid intake. Food and fluid charts were not always completed appropriately. Daily targets for food or fluids were not recorded in care plans. Where staff were recording how much fluid people were being offered and had actually drunk, this fell below the average amount of fluid the person should be offered. This placed people at risk of dehydration. Staff were recording what people ate, but not the quantities, therefore, this could place people at risk of malnutrition.
• Food and fluid charts were not analysed, and food and fluid audits were not carried out to ensure that

people were being supported with diets in line with the care plans and risk assessments.

• We saw one person's care plan documented that they should be on a low-calorie diet, however the food charts did not evidence that they were being served low-calorie meals. Information held in the kitchen showed that this person was being served a normal diet, so they were not being supported to lose weight in line with their care plan.

• Some people were weighed weekly however, the records were not always analysed to ensure that people's needs, targets and weights were being monitored and action being taken when needed.

• Menus were displayed outside each dining room. However, these were in small font, this meant that many people were not able to read it. This meant that people were, not always informed what meals were on offer, so they could decide if they wanted something else. In other areas there were pictorial menus available in the kitchen area of the dining rooms. However, we did not observe staff using these at lunch time to enable people were able to make a choice or to remind them of the meals on offer if they were unable to recall the lunch they had chosen for the day.
• We received mixed feedback from relatives. One relative said, "My [family member] does not need assistance, the food is quite good." Another relative said, "My [family member's] food is cut up, [they] have soft foods and [eats independently]. A 3rd relative said, "[My family member] needs to be supported as they [have eye problems], [staff] don't turn the plate around." A 4th relative said, "[My family member] has a sandwich in the evening, no-one gives [them] these. The tray was not right up to the bed, so [my family member] couldn't reach it."

The provider had not always reviewed people's nutritional, and hydration needs to ensure their needs were met. This was a breach of Regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Following the inspection, the provider informed us that they would be working to ensure menus were in larger fonts and improving pictorial menus that staff will be encouraged to use to enable people to make choices about their meals. We will check this at our next inspection

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Pre-assessments were completed prior to people coming to live at the service to ensure their needs could be met. These assessments covered people's physical, mental and social care needs; including personal care, nutrition, communication, cognition, mobility, continence and activities they enjoyed.
• Assessments were not always reviewed monthly or when required to ensure people's changing needs were met.
Adapting service, design, decoration to meet people's needs
• Although he home environment was adequately maintained, the design did not demonstrate that they had considered the needs of people with dementia. The décor of home looked clinical as all walls had been freshly painted in magnolia, including communal hallways. People's bedroom doors were not painted in different colours, not all rooms had people's name, memory boxes or a memorable picture on bedroom doors support people living with dementia to find their room with ease. Dining rooms and lounges were bland and void of colour.

Recommendation: The provider should seek guidance from a reputable source on how design which was conducive to people who live with dementia.

• The home appeared clean, the entrance of the home, and access to the garden were wheelchair friendly.

• People's rooms were decorated and personalised to their taste. There was appropriate signage throughout the home which promoted navigation and guided people to various communal areas. There were handrails in communal areas to help people to mobilise safely.
• There were lifts and stairways for easy access to alternate floors. There was also a security system in place to ensure people remained safe at the home.

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

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
• The registered manager and staff understood and worked within the principles of MCA. We observed staff asking people for their consent before supporting them.
• Where possible, legal authorisation such as a lasting power of attorney (LPA) was in place as required by law.
• People were encouraged to make various decisions for themselves and were provided information in formats that met their needs. People made day-to-day decisions about their food and clothing. However, where people could not make specific decisions for themselves for example about their medicines, finances, personal care needs and flu vaccination, appropriate mental capacity assessments and best interest decisions were in place.
• Where people living at the home had been deprived of their liberty for their own safety, DoLS authorisations were in place and any conditions placed on them were being met and kept under review.

Requires Improvement

# Is the service caring?

## Our findings

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

At the last inspection this key question was rated as requires Good. At this inspection this key question had deteriorated to Requires Improvement. This meant people were not always supported and treated with dignity and respect; and involved as partners in their care.

Respecting and promoting people's privacy, dignity and independence.
• We received mixed feedback about people's privacy and dignity being respected. One person told us, "Some [staff] are nicer than others." A relative said, "[Staff] pull the curtains and I wait outside." A 2nd relative said, "Sometimes, [my family member] is not shaved and [their] hair is greasy and [their] clothes can have food on them every day." A 3rd relative said, "[My family member's] eyes still have sleep in them. Ears are not cleaned." A 4th relative said, "[Staff's] bedside manner is not kind to [my family member] and there is a sullenness."
• We observed mixed interactions between people and staff. Some staff were kind and addressed people respectfully. Other staff were task focused and did not interact with people. We observed staff standing over people when supporting them to eat and drink, instead of sitting down, so they were at the same level.
• We carried out observations at lunchtime and saw that people who required support eating and drinking, had food placed in front of them. However, instead of informing people that they would be back to support them, staff walked away to support other people. This meant people's food may be cold by the time they ate it.
• People were not always treated in a dignified way. One person asked if they could have some more pudding was told loudly by staff member that they would have to wait till everyone else had finished theirs and if there was any left then they would be given some." Another person on a different floor of the home was on a low-calorie diet, as they were being served their pudding, a staff member shouted loudly across the dining room that the person should only be served a small portion as they were on a diet.
• We saw one person had was food all down their t-shirt, staff had not ensured their dignity was maintained by supporting to put on a clean top.
• The relative of one person who was living with dementia told us, that they brought in fresh pyjamas for them (to be changed daily) which were stored in their family member's bedroom cabinet. The night before the inspection, they said that their family member had been put to bed in a vest and disposable underwear, which was a frequent occurrence. A staff member who had supported the person to dress in the morning confirmed that had been the case. The relative told us they felt distressed this was happening not only because the person really felt the cold, but because there was a lack of dignity.
• Care records did not always detail what people could and could not do for themselves or give staff specific guidance on how to support people to encourage or maintain their independence.

Failure to ensure care is person centred and meets people's needs and reflects their preferences. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Following the inspection, the provider informed us that they would be improving care plans to reflect people's independence level and how this could be encouraged and maintained.

Supporting people to express their views and be involved in making decisions about their care
• We did not observe any communication aids being utilised to ensure people could be involved in decisions about their own care as much as possible.
• People were provided with a service user guide which included important information about the home and the standard of care and support people should expect, so they could make informed decisions for themselves. A relative commented, "There was lots of information, they gave me a booklet."

Ensuring people are well treated and supported; respecting equality and diversity
• Although most of the staff had received Equality and Diversity training, people's individual needs were not always taken into consideration when supporting them. For example, one relative told us that their family member could only hear out of one ear and that, "Staff don't speak to [them] on their good side."
• We observed staff treating people with kindness when they spoke to them. However, staff did not always engage people in meaningful conversation.

Requires Improvement

# Is the service responsive?

## Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant services were not always 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's care records did not document whether or not they or their relatives had been involved in planning their care.
• 7 out of 11 relatives told us that they were not involved in the planning of their family members' care. One relative said, "[Staff] don't involve me about [my family member's] care." Another relative said, "Any discussions come from me and not from [Staff], I have had to ask for [my family member's] care plan and told them that it does not reflect their care needs at all…. It feels like it is not managed by [Staff], but by me. A 3rd relative said, "[Staff] don't discuss risks with me."
• Care plans that were reviewed contained inconsistent or contradictory information that was not identified and corrected. For example, the care plan for one person who could not independently mobilise and used mobility aids, stated, "Staff to encourage [person] to stand and use own strength." This meant reviews were not effective and led to people being put at risk of harm, and receiving care which did not meet their individual needs.
• Social care plans were not in place or developed with people, to help keep people socially active and occupied if they wished.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Person-centred care.

• Following the inspection, the provider confirmed that all care plans will be updated by end of September 2023. The provider also told us that they have invested a digital system which will enable relatives to review daily care given to people in the home. This will support relatives to discuss care packages and care provision and enables them to be involved in care planning remotely. We will check this at our next inspection.

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
• We spoke with the activities co-ordinator, who told us that there were two activities coordinator on-site between Monday to Friday, with one at the weekend. The split their time between the 3 different floors.
• We observed on all floors throughout our inspection that people had been sat in front of the television in the lounge areas for long periods of time. Most people were asleep, and if there was a staff member present, they did not interact positively with people or encourage any interaction between themselves.

• People living with dementia were not provided with meaningful activities to stimulate them. For example, there were no sensory rooms, or soft toys, dolls, fidget toys, stress balls, and puzzles that could meet their sensory needs, to assist focus, concentration and provide a positive and calming environment.
• Some staff we spoke with told us that there was a need for more activities for people living with dementia, primarily on the 1st and 2nd floors as there was little stimulation. We observed some people who became confused or anxious. When this occurred, we did not observe staff offering reassurance to people or offering stimulation to distract them or to calm them.

• Overall, during the inspection we saw that there were limited activities on offer for people to participate in. This meant there was a lack of stimulation for people's well-being and risk of social isolation was not mitigated.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Person-centred care.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers'.

• People's communication needs had not been adequately assessed and recorded and there was no detailed plan in place to guide staff on how best to communicate with people.

• The provider failed to offer support or training to assist staff in their communication with people.
• Some people's care plans did not document their individual communication needs. For example, the care plan for one person who was non-verbal and had a visual impairment, documented that staff should encourage the person to communicate in their own way. The person used facial expressions and body language, and staff should anticipate their needs. There was no detailed guidance for staff on the facial expressions the person used and what they meant, or how staff should anticipate their needs. Another person's care plan stated that when someone approached them, they often expressed anxiety by leaning backwards away from staff or by flinching when staff were too close. There was no detailed guidance to support staff on how to manage this and support the person effectively.
• We were not assured the provider was making information available to people in alternative formats. The registered manager told us, that Information could be provided in different formats to suit people individually if needed. However, we did not see evidence of this.
• We received mixed feedback from relatives about how staff communicated with their family members. One relative said, "Yes, they communicate with [my family member] very well." Another relative said, "Yes [staff] do their best, [my family member] is very deaf and almost blind." A third relative told us that their family member had a hearing impairment and staff did not speak to them as outlined in their care plan." A 4th relative said, "Not all staff know [how to do] this."

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Person-centred care.

• Following the inspection, the provider informed us that communication care plans have been updated since the inspection to better reflect people's communication needs. This is ongoing as it is a collaborative effort between the provider, services users and their families. We will check this at our next inspection.

Improving care quality in response to complaints or concerns
• The service had a complaints policy, which provided guidance on how to raise a concern or complaint and the timescales for responding. However, the complaints policy was not being followed, the registered manager told us that they did not formally log and investigate complaints but dealt with them verbally.

• People and their relatives knew how to make a complaint. However, they told us their complaints were not dealt with effectively. On relative said, "We have raised a few things, and some have been resolved and others have not." Another relative said, "We have raised things, but staff don't come back to us, we have to keep asking. We feel that they don't get back to us. We would like to know what is going on." A 3rd relative said, "I complain about things, and nothing happens." A 4th relative said, "I have complained…., but not all the complaints have been resolved. The bathroom has a smell, and it hasn't been resolved, the shower curtain is hanging off."
• As complaints were not documented, analysis could not be carried out on complaints and learning could not be identified and used to improve the quality of the service.

This was a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support
• Relatives told us they had not always been consulted about people's end-of-life care needs. We saw one care plan that documented that the family did not want to discuss the person's wishes. Another care plan documented that discussions were yet to be had with the family. 2 relatives we spoke with told us, that there was a 'Do not resuscitate' form in place, but they have had no conversations about end-of-life care. 4 other relatives told us that they had not been involved or asked about end-of-life care for their family members.

• During the inspection the registered manger told us that they would ensure they had spoken to all people or their relatives about their 'End of Life' care wishes and the support they required. We will check this at our next inspection.

Inadequate

# Is the service well-led?

## Our findings

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

At the last inspection this key question was rated as Requires Improvement as areas of record management required improvement. At this inspection this key question has now deteriorated to Inadequate. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care
• People did not receive a service that was always well-led. The registered manager did not adequately understand their role and regulatory requirements. The registered manager and the provider lacked leadership and oversight of the service. The provider had not effectively addressed issues that we found at the inspection and people were exposed to unsafe care and treatment.

• Monitoring systems in place were not effective. This meant the provider had failed to ensure they always operated effective systems to assess and improve the care provided.
• Risks relating to falls, choking, epilepsy, asthma, diabetes, nutrition, medicines, call bells, mobility and communication were not always in place. Risks were not always monitored and regularly reviewed or addressed safely and effectively by the provider to ensure people were safe.
• Records were not always accurate, complete and updated when required. For example, when health professionals had given specific instructions, there was no information recorded to demonstrate the instructions had been actioned. This meant the provider did not have a robust system in place to identify these shortfalls.
• There were no epilepsy protocols, seizure charts or guidance in place for staff on what they should do if a person had a seizure. Not all staff had their medicine competency assessed to ensure they were competent to administer medicines This meant that the provider could not be assured that they had adequate systems in place to keep people safe.

• Quality assurance processes had failed to effectively identify and address the issues identified during this inspection.

The provider had failed to ensure systems for governance and management oversight were robust, safe, and effective. This placed people at risk of harm. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

• Following the inspection, the provider sent us an action plan to rectify all the issues found at this inspection. We will check this at our next inspection.

• There was a business contingency plan for emergencies, however there was no contingency plan in place

for when they internet failed.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• The registered manager had held regular monthly staff meetings. These were not always effective. Issues were identified with staff, such as training and recording peoples' fluid intake, however there was no records to demonstrate these issues had then been followed up. Also, the minutes from the June 2023 meeting did not demonstrate that learning from accidents and incidents had been disseminated to all staff.

• The registered manager told us that they had regular residents' meetings and relatives' meetings separately. We saw that the last two relatives' meetings were held in January 2023 and June 2023.The registered manager also confirmed that a residents/relatives' annual survey had not been carried out for 2022. 6 out of 8 relatives told us that they were either not aware that relatives' meetings were being held or that they had not received a survey to give feedback. One relative said, "There hasn't been any Zoom meetings this year as far as I know. When we ask for things/information, nothing happens, they don't get back to us." Another relative said, "No meetings this year for family members." A 3rd relative said, "I have not been asked to give feedback, I have flagged up a couple of things and nothing has changed." A 4th relative said, "No surveys." Overall, there were opportunities missed for gaining the views of people and relatives and to involve them in driving improvement or in demonstrating a commitment to providing person centred care.
• We saw that the meeting in January 2023 recorded that a transport service was being trialled for resident outings. Residents were going to be asked at future meetings where they would like to go this included garden centres, beaches and shopping trips. However, the provider's arrangements to provide transport did not work out as the chosen transport provider was unable to deliver on the necessary transport requirements. No other arrangements were made to take people on outings. A relative said, "I know that [my family member] would like to have a change of scene and really enjoys being out."

• A residents meeting was held for people living on the ground floor on 6 July 2023. One service user had said that their bed was not being made and they had spoken to care staff. The response they received was that the service user had to ask staff to make their bed. There were no records to show this was followed up and any action taken was not noted in subsequent meetings or in the person's care plan.
• The registered manager told us that a residents/relatives' annual survey had not been carried out for 2022. One relative said, "I have not been asked to give feedback, I have flagged up a couple of things and nothing has changed." Another relative said, "No surveys." Overall, there were opportunities missed for gaining the views of people and relatives and to involve them in driving improvement or in demonstrating a commitment to providing person centred care.

This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

• Following the inspection the provider informed us that as an alternative to not being able to carry out an annual survey in 2022, they carried out a carehome.co.uk drive to obtain feedback. However, the responses did not demonstrate the questions people were asked and the feedback received. There were also no records to show if there were any shortfalls were and if these had been rectified.

• We received mixed feedback about the registered manager. Some relatives said, "The manager seems to be very good and very approachable and "The Manager is good, he is around and speak to us, very sociable and welcoming." Other relatives said, "I would like there to be more of a relationship with family members." Another relative said, "I am not sure how engaged [the manager] actually is on a day-to-day basis, they

might not know that staff are struggling with some residents. A third relative said, "Words need to be put in action. There needs to be direction and [staff] told what to do and sharing information which we need to know."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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
• People did not always receive good outcomes. Since the last inspection in November 2020, the service had failed to embed a culture that looked to achieve positive outcomes for people.
• We received mixed feedback about the management of the service. One relative said, "I think it is pretty well run, I think it is well organised." Another relative said, "On the whole I think it is really good." A 3rd relative said, "It seems to be organised quite well." Some relatives told us that improvements were needed. One relative told us, "I would like one member of management team to be there at the weekends. I think they are just there Monday to Friday. They could look around and pre-empt things." Another relative said, "At night and weekends, I feel there is no-one in charge." A third relative said, "I would say that in some respects there will be room for improvement, are the staff supported? It is a bit top down. Some of the organisational processes could be better." A 4th relative said, "The administrative side, the communication side needs greatly improving."

Working in partnership with others
• The service worked in partnership with organisations, including the local authority, and other health care professionals such as GPs and district nurses.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>People's needs were not always assessed and care plans were not person-centred<br><br>People or their relatives were not involved in planning their care needs |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br><br>People dignity and privacy was not always maintained and independence was not always promoted |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Staff were not effectively deployed to meet people's needs in a timely manner |