Four Seasons (Evedale) Limited

Charnwood

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

We conducted an unannounced inspection at Charnwood on 19, 26 and 28 November 2018. Charnwood is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Charnwood is situated in Carlton, Nottinghamshire and is operated by Four Seasons (Evedale) Limited. The service accommodates up to 88 people. At the time of our inspection there were 55 people living at the home. The home is split across two units, both of which have two floors. Charnwood House is staff by registered nurses and care staff and primarily support people living with dementia. Charnwood Court is also staffed by nurses and care staff, however people's needs are mainly related to their physical health needs.

At our last inspection in April 2017 the service was rated good. At this inspection we found the quality of some aspects of the service had deteriorated. Consequently, we found concerns across a range of areas including safety, medicines management, staffing and leadership and governance. This resulted in several breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

There was no registered manager in place at the time of our inspection. The previous registered manager had left the home in early 2018. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. There was a new manager in post who started in October 2018, they had applied to register with us and this was being processed at the time of our inspection.

During our inspection we found the service was not safe. Risks such as falls, choking and behaviours were not always managed safely. This placed people at risk of harm. Opportunities to learn from accidents and incidents had been missed. We found multiple concerns about the management and administration of medicines, this placed people at risk of not receiving their medicines as prescribed. There were not always enough staff to meet people's needs, people told us this had a negative impact on the care they received. Action had not always been taken to protect people from the risk of abuse and improper treatment. People were exposed to verbal abuse. In addition, there was a risk safeguarding incidents may not be appropriately investigated in a timely manner resulting in people being left at risk of abuse. Improvements were required to ensure the home was clean in all areas. Safe recruitment practices were followed.

Staff lacked training in some key areas. This meant there was a risk people may be supported by staff who did not have sufficient training or competency to provide safe and effective support. Staff did not always receive formal supervision or support. People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible; the policies and

systems in the service did not support this practice. Mealtimes were not always positive experiences for people and there was a risk this may have a negative impact upon how much people ate. People had access to a range of health care professionals, but care plans required more information about people's health to ensure consistent support. Overall, the home was adapted to meet people's needs.

People did not receive consistently kind and caring support. There was an inconsistent approach to involving people about decisions about their care and support. Staff did not always treat people in a dignified manner. People told us they were supported to be as independent as possible. People told us staff respected their right to privacy. People had access to advocacy services if they required this.

People did not always receive consistent support that met their needs. Support plans were not always up to date and did not reflect people's needs. The risk of inconsistent support was increased by the use of temporary agency staff. People were not always provided with opportunity for meaningful activity. There were systems in place to respond to complaints. However, concerns were not always resolved. People's diverse needs were accommodated.

There was a lack of leadership, coordination and oversight at Charnwood, this had a negative impact on the quality and safety of the service. Although there were auditing systems in place there had been a failure to identify and address some serious issues. Where issues had been identified timely action was not taken to make improvements. Systems to analyse, investigate and learn from incidents were not effective. Records of care and support were not accurate or up to date. Following our inspection, the provider developed a comprehensive action plan detailing actions taken and planned to make improvements and reduce risk.

This was the first time the service had been rated as Inadequate. During this inspection, we found five breaches of the Health and Social Care Act 2008 regulations. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks associated with people's care and support were not always managed safely. Medicines were not managed and administered safely. Opportunities to learn from accident and incidents had been missed. There were not always enough staff to meet people's needs. People were not always protected from the risk of abuse and improper treatment. Improvements were required to ensure the home was clean in all areas. Safe recruitment practices were followed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Further work was needed to ensure people's rights under the Mental Capacity Act 2015 were protected. Staff required more training to enable them to provide safe and effective. Mealtimes were not always positive experiences for people. People had access to a range of specialist health care professionals, but care plans required more information about people's health to ensure consistent support. Overall, the home was adapted to meet people's needs.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People did not receive consistently kind and caring support. There was an inconsistent approach to involving people about decisions about their care and support. Staff did not always treat people in a dignified manner. People were supported to be as independent as possible. People had access to advocacy services if they required this.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not consistently receive personalised care that met their needs. Staff were not always responsive to people's needs. People were not always provided with opportunity for meaningful activity. There were systems in place to respond to complaints. However, concerns were not always resolved. People's diverse needs were accommodated.

Is the service well-led?

Inadequate

The service was not well led.

There had been a failure to identify and address some serious issues. There was a lack of leadership, coordination and oversight at Charnwood. Records of care and support were not accurate or up to date. Following our inspection, the provider developed a comprehensive and robust action plan detailing actions taken and planned to make improvements and reduce risk.

Charnwood

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service to look at concerns we received about the quality and safety of the service and to provide a rating for the service under the Care Act 2014.

This unannounced inspection took place on 19, 26 and 28 November 2018. The inspection team consisted of two inspectors, a specialist nursing advisor and two Experts by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our inspection visit, we reviewed information we held about the service. This included information received from local health and social care organisations and statutory notifications. A notification is information about important events, which the provider is required to send us by law, such as allegations of abuse and serious injuries. We also contacted commissioners of the service and asked them for their views. We used this information to help us to plan the inspection.

During our inspection visit, we spoke with 21 people who used the service and the relatives or friends of eight people. We spoke with six members of care staff and the activities coordinator. In addition, we spoke with the following members of the management team; the service manager, two members of the resident experience team, the acting area manager and the regional director.

To help us assess how people's care needs were being met we reviewed all or part of 13 people's care records and other information, for example their risk assessments. We looked at people's medicines records, four staff recruitment files, training records and a range of records relating to the running of the service, for example, audits and complaints.

We carried out general observations of care and support and looked at the interactions between staff and people who used the service. We also 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.

As this was a responsive inspection we did not ask the provider to complete a 'Provider Information Return' prior to our inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We gave the provider the opportunity to share this information with us throughout the inspection.

Inadequate

Is the service safe?

Our findings

People were not protected from risks associated with their support, such as falls and choking. Measures were not always in place to reduce risk and staff did not consistently follow guidance intended to ensure people's safety. An external health professional had recommended that one person was provided with modified texture food and drink to reduce the risk of choking. This guidance had not been incorporated into their care plan, staff were not aware of this and consequently, did not follow the advice. This placed the person at risk of choking. Records showed another person was at high risk of falls and had sustained a serious injury as a result of a fall. Despite this, we observed, and the registered manager told us, there were no control measures in place to alert staff to the risk of falls when the person was alone in their bedroom. This placed them at risk of sustaining injury resulting from a fall. A failure to manage risks safely placed people at risk of sustaining harm.

Risks associated with people's behaviours were not managed safely. Several people experienced behaviours resulting from anxiety and distress which placed others at risk of harm. Incident records documented multiple incidences of verbal and physical altercations between people. Despite this, care plans did not contain enough information about how manage this and reduce the risks to others. Staff did not have an adequate understanding of distraction and escalation techniques. Throughout our inspection we observed that staff failed to intervene appropriately in verbal altercations on several occasions. This resulted in some people suffering emotional distress.

Staff responses to behaviour was not always appropriate. For example, we observed a person pinch a member of staff. The member of staff forcefully removed the person's hand and said, "that's not nice" twice. This was a restrictive form of behaviour management and there was no attempt made to understand the reason for the behaviour. Behaviour records showed some people were routinely 'taken to their room' after incidents. This was a restrictive intervention that did not respect people's rights.

Risks to staff were not managed safely. We saw multiple records of staff being hit, kicked and punched by people living at the home. Staff told us they did not get support from management with this, they just talked with other staff. A member of staff told us this they just expected violence at work. This failure to ensure the safety of staff placed them at risk of harm.

Opportunities to learn from adverse incidents had been missed. Care plans had not been reviewed or updated as a result of incidents such as falls or altercations. For instance, records showed one person had fallen twice in the past month. However, their care plan did not reflect the increased risk did not contain any information about how to reduce risk.

People were at risk of not receiving their medicines as prescribed. We found missing signatures across 10 medicines records. Some of these were for high risk medicines, such as medicines used to manage diabetes and mental health medicines. A failure to give medicines as prescribed could have had a negative impact on people's health and wellbeing. Time specific medicines were not always administered as required. Some people were prescribed medicines which should be given in the 30-60 minutes before food to ensure their

effectiveness. There were no consistent arrangements in place to ensure this was followed, consequently medicines records did not evidence medicines had been given as required. This may have had a negative impact on the effectiveness of these medicines.

Medicines records were not always completed appropriately to ensure safe administration. Hand written medicine records were not always checked and signed by two staff. The failure to ensure medicines records are correctly transcribed and appropriately checked increases the risk of error.

Medicines were not always stored safely. We found a large quantity of medicine stored on the floor in a clinic room, it was dated 12 days before our inspection. This had not been checked in, which meant there was no record of it in the home. This was not safe as it increased the risk of misuse of medicines. The system for stock rotation was not robust and we found some medicines which were out of date. This meant there was a risk ineffective medicines may be administered. Drinks thickeners were not stored safely. Thickener was found in a communal area. This could have been accessed and potentially ingested by people and this placed them at risk of harm.

There was a risk people may not receive the support they require in the event of an emergency. Equipment which may have been needed if a person's heath declined was not charged and ready to use and an emergency grab bag was poorly organised and hard to find things in. This could have caused a delay to people getting the support they required in an emergency.

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

There were not always enough staff to meet people's needs and ensure their safety. We received mixed feedback from people living at Charnwood. One person told us, "There are not enough staff here. The staff say it themselves. We have to look after each other." Some people told us they were left on the commode for prolonged periods and one person said they were fearful of being left on the toilet so tried to avoid it. People also gave mixed feedback about the speed of responses to call bells. Whilst some people told us they did not have to wait long, others commented that it depended on how many staff were on shift. Peoples families also commented that there were times when there were not enough staff. One relative told us, "They are short staffed. If there's only two staff on and one person needs them both, then it means there's nobody to help anybody else. That's one of the reasons I come such a lot because I can help [relation] myself." Staff told us planned staffing levels were sufficient but commented that unplanned absences had a negative impact on the care people received. The manager told us the lounges were meant to be supervised at all times during the day. However, records showed evidence of unwitnessed falls in communal lounges indicating that staff were not present at these times. A dependency tool was used to determine staffing levels. However, we found some dependency assessments did not reflect people's actual need. This meant there was a risk that staffing levels may not be based upon people's needs. This meant there was a risk people's needs may not be met in a safe or timely manner.

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

In response to our concerns the management team took immediate action to increase staffing levels whilst they reviewed staffing levels. We will assess the impact of this at our next inspection.

Although people told us they felt safe, we found people were not always protected from the risk of abuse and improper treatment. Staff did not diffuse altercations between people and consequently, people were subject to verbal abuse. Throughout our inspection, we observed multiple verbal altercations between

people in a communal area, staff were present but did not intervene.

Referrals had not always been made to the local authority safeguarding adults team. Although records showed some referrals had been made to the local authority safeguarding adults team, some altercations between people had not been reported. We also found there had been delays of up to 4 weeks in making some safeguarding referrals. This meant there was a risk safeguarding incidents may not be appropriately investigated in a timely manner resulting in people being left at risk of abuse.

Although people told us they thought the home was clean we found further improvements were required to ensure the home was sufficiently clean in all areas. Effective cleaning procedures were not in place for some items of equipment used in people's care and support. Some equipment such as hoists and wheelchairs were sticky, dusty and marked with food debris. This was an unhygienic practice which meant that people were using equipment which was not clean. There were other aspects of the environment that did not promote the prevention and control of infection. Some walls were damaged and wall paper was torn in some areas, this did not facilitate effective cleaning and could harbour bacteria.

Safe recruitment practices were followed. The necessary steps had been taken to ensure people were protected from staff that may not be fit and safe to support them. For example, before staff were employed, criminal record checks were undertaken through the Disclosure and Barring Service. These checks are used to assist employers to make safer recruitment decisions.

Requires Improvement

Is the service effective?

Our findings

There was a risk people may be supported by staff who did not have sufficient training or competency to provide safe and effective support. People's feedback about the competency and skill of staff was mixed. Some people told us staff were well trained. However, other people felt staff were not appropriately skilled. One person told us, "I think some staff know what they are doing others don't. Some are trained and some are not."

Training records showed staff lacked training in some key areas. For example, 17 of the 50 care staff did not have practical moving and handling training. This meant there was a risk people may be supported to mobilise by staff who did not have sufficient skill to provide safe support. Only 16 staff had received training in person centred care and during our inspection we observed several examples of task focused care that did not follow the principles of person centred care. Staff did not have any training in managing behaviour. This was a concern given the number of behavioural incidents documented in the home. This meant there was a risk staff did not have the required competency to safely manage people's behaviours and during our inspection we found people did not receive appropriate support in this area. Training was planned for staff, however at the time of our inspection; the above insufficiencies placed people at risk of not having their needs met safely or appropriately.

Staff did not always receive regular supervision of their work. Although staff told us, they felt supported on an informal basis they had not always been provided with formal supervision. Records showed some staff had not had individual supervision for ten months. This meant that staff were not given formal support and opportunities to reflect on practice and share concerns may be missed. This was of concern given the above gaps in staff training and knowledge.

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

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.

Further work was needed to ensure people's rights under the MCA were protected. Capacity assessments had not always been completed to reflect people's decision-making abilities. Some people's care plans recorded they did not have capacity in areas such as medicines management. However, no formal assessment of their capacity had been undertaken, consequently, there was no documentation on how staff should act in their best interests. Several people were subject to restrictions such as movement sensor equipment. Some people's capacity to consent to this had not been assessed. This meant there was no evidence that this decision was in the person's best interests and the least restrictive option. The management team told us capacity assessments would be reviewed and implemented as needed. We will

assess the impact of this at our next inspection.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. 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. DoLS had been applied for as required and where conditions were in place these were complied with.

Feedback on the quality of food was mixed. One person told us, "I like the food. It's alright." Another person said, "Oh yes we have lots to eat. I have a beer sometimes with my dinner." Other people we less positive about the food, one person said, "We get plenty and its hot but, sometimes it's a bit dry."

The dining experience was not always positive. Much of the support provided by staff at meal times was functional and task focused. There was very little conversation between the staff and people living at Charnwood. Some people were not offered assistance and consequently ate very little. Some people were not served their meals in a timely manner. One person waited at the dining table for a period of 45 minutes for their meal. Some people could not remember what they had ordered as they had chosen their meal earlier in the day, and staff did not always tell them what they were served. Other people were not provided with their chosen option. Occasionally people were shouting at each other and although staff tried to calm the situation this resulted in anxiety to others. The poor dining experience could have had a negative impact on people's nutritional intake.

People told us they were supported to attend appointments and see healthcare professionals when needed. One person told us, "The doctor comes to visit and check people on a Tuesday or comes if something is wrong. If I have to go to hospital the staff come with me." People's families told us the staff team communicated changes in people's health needs with them. Although evidence showed staff had sought professional advice in response to changes in people's health, advice was not always incorporated into care plans and records did not evidence that advice was consistently followed. For example, an external specialist had made a range of recommendations around how best to support a person in relation to anxiety and resultant behaviour. This had not been incorporated in to the care plan and we observed staff did not follow this guidance. A member of staff told us they managed the person's behaviour by telling the person their behaviour was "wrong" this was not an approach recommended by the professional.

When people had specific health conditions, care plans did not consistently contain adequate detail for staff to provide effective support. For example, one person had a health condition but their care plan did not contain any information about it or how to manage the risks associated with it. Although a nurse told us staff had a good understanding of the condition, there was not information for new and agency staff. This lack of information placed people at risk of not receiving the required support.

Although nationally recognised assessment tools were used, these were not always used effectively. For example, one person had been assessed as being at high risk of pressures sores. The risk assessment recommended regular repositioning, However, records showed they were not repositioned as frequently as required. This failure to follow good practice guidance effectively could have had a negative impact upon people's health of wellbeing.

Overall the home had been adapted to meet people's needs. Aids and equipment had been installed in throughout the home to enable people with mobility needs to navigate around the building and there was a call bell system to ensure people could request staff as required. There were communal lounge and dining

areas, on each unit which meant people had space to spend time socialising with friends and family. There were also smaller lounges which people could use if they wanted more privacy. Some areas of the home required redecoration and the manager told us this was planned. Although there was dementia friendly signage throughout the building there were other aspects of the service which did not cater to needs of people living with dementia or memory loss. For example, some bedroom doors had photos to help people orientate themselves, some had basic written information and other bedrooms had no information at all. The activities coordinator told us this was work in progress.

Requires Improvement

Is the service caring?

Our findings

People did not receive consistently kind and caring support. Many people commented positively on the approach of staff. One person told us, "They are all very nice with us." Another person said, "'They are very good. They help me to get dressed and they are very gentle." However, this was not consistent and some people told us the quality of care and approach of staff varied depending upon staff member. This was reflected in our observations. In Charnwood Court we observed most interactions were warm, respectful and attentive. In Charnwood House, we saw some staff were abrupt, authoritative and task focused in their interactions. For example, we observed a person trying to get out of the front door, the member of staff raised their voice and told the person they could not leave, they did not take the time to find out what was bothering the person nor did they offer any reassurance or alternative activity to distract them. Consequently, the person became increasingly agitated.

Staff did not always promote people's dignity. Again, this varied between staff members. For example, we observed one person talking loudly about sensitive personal issues. Instead of acting to protect the persons dignity the staff member present looked at another staff member and laughed loudly. Another person was observed to attempt to eat some food from the floor. A member of staff was present and repeatedly said "No," to the person. The member of staff walked off and the person proceeded to eat the food off the floor. This did not promote people's dignity.

We received mixed feedback about people's involvement in choices and decisions. Most people who could communicate their wishes told us they were offered choices and these were respected by staff. However, we observed that when people were not able to make their wishes known easily staff did not always involve them in decisions. For example, we observed staff moving one person from table to table at a meal time without consulting them about this. This lead to them becoming increasingly agitated. Staff talked about the person rather than to them. Similarly, some people and their families told us they had been involved in planning their support. However, others commented that they had not been involved and did not know if they had a care plan or not. This demonstrated there was an inconsistent approach to involving people about decisions about their care and support.

The manager told us people had access to an advocate if they wished to use one. Advocates are trained professionals who support, enable and empower people to speak up. Several people were using Independent Mental Capacity Advocates (IMCA) at the time of our inspection. IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions. We noted that information about advocacy was not obviously displayed in the home which meant people were reliant upon staff to access an advocate to support them to express their views.

People told us staff promoted their independence. One person said, "Oh yes I am independent. I get up when I want, I dress myself and I put my dirty clothes in the laundry." Some people's care plans contained information about how to promote people's independence, but this was not consistent. Several care plans did not contain up to date information about how to support and encourage independence and this placed people at risk of inconsistent support in this area.

Overall people told us that staff respected their privacy. One person commented, "They always knock on the door before they come in to my room." We observed this to be the case throughout our inspection. We saw that staff knocked on bedrooms doors before entering and that they were careful to close toilet doors when assisting somebody.

People were supported to maintain relationships with friends and family, and people's friends and relatives were welcome to visit Charnwood. There were no restrictions upon visitors to the home.

Requires Improvement

Is the service responsive?

Our findings

People gave variable feedback about the support they received. Some people, mainly those who required less support from staff, told us they were happy with their support and said they could "please themselves." However, others commented on institutional routines and staffing issues which had a negative impact upon the care they received. One person told us, "I get up at eight. I think they get everybody up then, but I wish I could stay in bed. I wish they would leave me sometimes." Another person said, "They (staff) are all nice people, but the only problem is when you want to go to the toilet at lunchtime and then they will say they haven't got time to help you because they're getting the dinners out. You can't plan when you want to go can you?"

We found people did not always receive personalised responsive care and support. Staff were not always available, or did not always respond to meet people's needs. In Charnwood Court there was only one member of staff in the communal area for most of the morning on 19 November 2018. This meant most people were left unattended. One person was distressed and kept saying 'Please, please,' but there were no staff around to help. In Charnwood House, although there were staff available, we observed that at times all four of them were completing records. Although some staff responded to people's requests for support, other staff did not, or were dismissive. For example, we saw two people were becoming verbally abusive towards each other. Staff did not try to manage the situation by providing re-direction or by offering the people an alternative seating area, they appeared to carry on oblivious to the escalating situation. This did not meet people's needs.

Care records did not always show people were provided with the care they required. During our inspection we received concerns that people were not provided with regular support to maintain their personal hygiene. Record keeping was poor in this area. There was no evidence in 14 of the 18 people's records we viewed of them being offered baths or showers in the four weeks before our inspection. This was not dignified and did not meet people's needs.

Care plans did not always reflect people's needs or preferences. For example, one person's care plan was inaccurate in almost every area. It stated they were independently mobile; however, we saw them using a wheelchair. It stated they were happy and bubbly, but they cried and screamed for a period of approximately four hours during our inspection. In addition, their care plan did not contain key information about their dietary needs and we found staff did not have adequate knowledge of this. There were inconsistencies in several other care plans we looked at. Some people had detailed information about things such as their preferences, interests and end of life wishes, whereas other people had no information in these areas. For example, some people had chosen not to be resuscitated should their health worsen. However, there were no end of life care plan in place for some of these people, which meant their need and preferences for the end of their lives may not be met. This placed service users at risk of unsafe support that did not meet their needs.

The care and support provided at Charnwood did not reflect the preferences of service users. There was a significant lack of meaningful activity and feedback about activities was poor. One person told us, "There is

only one activities coordinator and they very rarely go over [to Charnwood House, dementia unit]. There isn't much happening here (Charnwood Court) but it's worse over there." Another person told us, "It depends what staff are on, there is never much on." There was an activity coordinator employed at the home and recruitment was underway for a second activity coordinator. We observed, and people told us, that the activity coordinator was not always able to fulfil their role as they were asked to undertake additional roles, such as supporting people to health appointments. This had a negative impact upon the opportunities available to people. The activities coordinator told us they organised events such as trips into the local community and they had built links with local schools and churches. However, in contrast some people commented they did not have the opportunity to get out. One person commented, "The staff never take us out. We never went out in all that beautiful weather in the summer. It is like a prison." Staff told us they sometimes organised activities for people. However, we observed these were not always well planned. During our inspection, we observed staff doing a karaoke session. There was very little attempt made to involve people and although two people appeared to be enjoying this, there were several other people who were clearly becoming agitated by the noise.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements were needed to ensure people's concerns were acted upon. Records showed formal complaints were addressed in line with the provider's complaints policy and most people commented that when they had made formal complaints these had been resolved to their satisfaction. In contrast, concerns raised informally were not recorded and consequently we found effective action was not always taken to resolve concerns. For example, one person told us there was an issue with their bed, they had reported this to staff, but it had not been addressed. We reported this to the management team, who were unaware of the issue and took immediate action to resolve the issue. However, this failure to communicate concerns had led to the person being uncomfortable for a prolonged period. The provider told us they would implement a new system to ensure concerns were communicated effectively.

Further work was required to ensure the provider met their duties under the Accessible Information Standard. The Accessible Information Standard ensures that all people, regardless of impairment or disability, have equal access to information about their care and support. Although information leaflets were available to people in different formats and languages, information displayed around the home was not accessible to some people and we did not observe staff using alternative methods to communicate with people who had limited understanding of written or verbal communication.

People's diverse needs had been identified and accommodated. People told us they had felt they were treated fairly and were free from discrimination. People's religious and spiritual needs were catered for. For example, people who wished to practice their religion were provided with opportunities to do so at the home.

Inadequate

Is the service well-led?

Our findings

There had been a failure to identify and address some serious issues at Charnwood. Although the provider conducted regular audits at the home these had not identified the scale and extent of concerns at the home. The manager conducted daily walk arounds of the home. These looked at the cleanliness of home, provision of support, staff interactions and care plans. They were not effective in identifying concerns. Very few issues had been identified and where areas for improvement had been found there was not clear action plan detailing who would make the required changes.

The outcomes of some audits were contradictory. For example, a weekly medicine audit was conducted on 5 November 2018, by the manager, no issues were identified. However, the provider conducted a medicines audit on 8 November 2019 in which the home scored 59%. The discrepancy between the outcomes of the audits had not been identified and consequently no action had been taken to ensure the competency of the staff conducting weekly medicines audits. Furthermore, action plans developed as a result of audits were not implemented effectively. Several actions had been developed in response to the provider's November medicines audit. The manager had marked all actions as 'in progress'; however, no action had been taken to make improvements. Consequently, we found ongoing, serious concerns about medicines management at our inspection.

Action was not always taken to address known issues. The Local Authority and Clinical Commissioning Group had conducted an audit in March 2018. This identified serious issues across the service in areas such as infection control, care planning and risk management, staff training, hydration and nutrition, person centred care and leadership. Although the provider had submitted an action plan, improvements had not been made or sustained. Consequently, at our inspection we found continued concerns in these areas. The failure to make and sustain improvements placed people at risk of receiving unsafe support that did not meet their needs.

There was a lack of leadership, coordination and oversight at Charnwood. Vacancies in the management and nursing teams meant agency nurses were responsible for managing some shifts. During our inspection, we found agency nurses were not always effective in managing the performance and conduct of the staff team to ensure people received the support they required. For example, we saw that an agency nurse who was running the shift did not identify or address issues with the deployment or behaviour of staff. This had a negative impact upon the quality and safety of the service provided at Charnwood.

There was no effective system for analysing, investigating and learning from behavioural incidents. Behavioural incidents were recorded on behaviour charts. However, trends of these incidents, such as the location, timing or staff involved were not effectively analysed and no changes were made to support plans as a result of the analysis. This failure to conduct effective analysis of incidents meant opportunities may have been missed to identify ways of preventing future incidents and exposed people to the risk of potential distress or harm.

Records of care and support were not accurate or up to date and staff did not always have access to clear

information about the people they were supporting. Support plans were not accurate or up to date. In addition, records of care and support, such as food records, were also not fully completed. The failure to ensure complete and contemporaneous records meant we were unable to identify if people had received the care and support they required.

There were limited opportunities for people to influence the running of the home. This was reflected in people's comments, most people told us they were not asked for their views on the service and did not recall attending any meetings. Although people and their families had the opportunity to complete satisfaction surveys, there had not been any recent meetings for people living at the home. This meant opportunities to improve the service may have been missed.

Although, there was evidence to demonstrate the provider had worked in partnership with other agencies. However, a lack of effective systems for sharing information and acting on concerns meant that this partnership working was not always effective. For example, although external agencies had provided advice about how best to support people this was not always followed. This had a negative impact on the quality and safety of the service.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection, we wrote to the provider and asked them to take urgent action to address the most serious risks outlined in this report. In response, the provider developed a comprehensive and robust action plan detailing actions taken and planned to make improvements and reduce risk. Additional resources were immediately deployed to the service including enhanced management support. The provider shared evidence of improvements made with us.

Improvements were underway to share information with staff and involve them in the running of the home. Records showed that meetings for staff had not been held regularly. This had improved under the leadership of the current manager. Records showed a recent staff meeting had been held, this focused on sharing information with the team and addressing issues. The manager told us they planned to hold regular staff meetings going forward.

It is a legal requirement that a provider's latest CQC inspection report is displayed at the service and online where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. The provider had displayed their most recent rating in the home and on their website.

We checked our records, which showed the provider, had notified us of events in the home. A notification is information about important events, which the provider is required to send us by law, such as serious injuries and allegations of abuse. This helps us monitor the service.

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 People were not provided with person centred support that met their needs and preferences. Regulation 9 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected from risks associated with their care and support. Medicines were not managed safely. Regulation 12 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to ensure the quality and safety of the home were not effective. Regulation 17 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not always deployed effectively to meet people's needs and ensure their safety. Regulation 18 (1) (2)