Benslow Management Company Limited

Chiltern View

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Chiltern View is a residential care home providing personal care to up to 36 people. The service provides support to older people and people who have dementia. At the time of our inspection there were 29 people using the service.

The premises is on three levels with bedrooms on the first and second floors. On the ground floor there are further bedrooms and communal areas including a lounge, dining area and conservatory. There is also shared garden space. Administrative and management offices are also on the ground floor.

People's experience of using this service and what we found
The service was not well-led. The provider and registered manager did not use quality monitoring systems effectively to identify and address shortfalls in the service.

People were not protected from harm and lessons were not learnt when things went wrong. Risks to people's safety were not adequately assessed and staff did not act to reduce the risk of harm. People at risk of pressure damage to their skin did not receive appropriate support to reduce the risk of new or worsening injury.

People were not protected from the risk of malnourishment or dehydration. People at very high risk of weight loss did not receive support in line with their care plan to ensure they maintained adequate food intake. Medicines were not managed safely, and staff did not follow good practice when administering medicines. The service was not clean and appropriate measures to protect people from the spread of infection were not followed. The premises had not been designed or maintained to meet the needs of people living there.

There were not enough staff to meet people's care and support needs. There were a high number of agency staff used to cover shifts, some of whom lacked the required skills and experience and were unfamiliar with the needs of the people living at the service. Although permanent staff provided better care, they were extremely busy and did not have time to provide good quality outcomes for people. People did not receive timely care and were left for long periods with no interaction or support from staff. People, particularly those cared for in their bedrooms, were left isolated with no stimulation. Many staff did not engage with people or initiate conversation. There were no opportunities for meaningful occupation offered to people.

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

People were not always treated with dignity and respect. Staff did not always treat people with kindness and compassion and the language used to describe people was not always respectful. People, or their relatives where appropriate, did not always feel supported to be involved in making decisions about their care.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 09 July 2019) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
This inspection was prompted by a review of the information we held about this service. It was also prompted in part due to information received from the Environmental Health Officer and the Fire Safety Officer about risks found at the service. This information indicated a risk of shortfalls in the management oversight of the service. A decision was made for us to inspect and examine that risk.

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.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

Although initially slow to respond to concerns we raised with them, the provider has since increased staffing levels and developed a plan to support improvements to the service. The newly appointed operations director is working closely with the registered manager to make improvements.

The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to leadership, staffing numbers and skills, safe care, protecting people from harm, infection control, medicines management, nutrition and hydration, dignity and respect, person centred care and a lack of meaningful engagement for people.

In response to the areas of very high risk we found at the inspection we took urgent action to keep people safe. This included placing conditions on the provider's registration to restrict them from admitting new people to the service and requiring them to take specific actions to reduce risks to people.

Following this inspection we took enforcement action to cancel the registered manager 's registration and to remove Chiltern View from the provider's registration so they are unable to continue to provide accommodation and personal care from this location.

The overall rating for this service was 'Inadequate' and the service was therefore in 'special measures'. This meant we kept the service under review and, if we did not propose to cancel the provider's registration, we

would re-inspect within 6 months to check for significant improvements.

The provider had not made enough improvement within this timeframe and there was still a rating of inadequate for a key question or overall rating, We took action in line with our enforcement procedures. This meant we began the process of preventing the provider from operating this service. This led to varying the conditions of their registration. to prevent them from operating the service.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Chiltern View

Detailed findings

Background to this inspection

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

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

Inspection team
This inspection was carried out by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Chiltern View 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. Chiltern View is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced. Inspection activity started on 31 August 2022 and ended on 28 September 2022. We visited the service on 31 August 2022, 02 and 07 September 2022.

What we did before the inspection
We reviewed the previous inspection report and all information we had received about the service since the last inspection. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We sought feedback from the local authority about the service. We used all this information to plan our inspection.

During the inspection
During the inspection we spoke with four people who used the service, 16 relatives, five visiting health and social care professionals, and nine staff, including the registered manager, the deputy manager, care staff and agency staff, the provider's managing director and their operations director. We carried out observations of care and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We reviewed a range of records. This included recruitment documentation for three staff and documents relating to staff training. We also reviewed care records for eight people and medicine and supplementary records for multiple people. We reviewed various policies and other records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

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

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

At our last inspection there were not enough staff deployed to ensure people's care and support needs were met and they were safe. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had not been made and the provider was still in breach of Regulation 18.

Staffing and Recruitment

- There were not enough suitably skilled and experienced staff on shift to safely meet the needs of the people living at the service. Although people's needs had been assessed using a dependency tool, this had not been used effectively to calculate the number of staff required. Staffing levels on shift were unchanged from those found at the last inspection where we found they were insufficient. Relatives told us, "I don't see many staff present. They take time to come" and, "They are short staffed and struggle."
- There were six people cared for in bed who required repositioning every two hours and relied on staff for all of their care and support needs. Many other people required the support of two staff for their personal care and mobility needs. At busy times of day this left insufficient staff to meet the needs of people within the communal areas of the home and other people who chose to remain in their rooms.
- The service relied on a high number of agency staff to cover gaps in the rota. On the first day of the inspection, all the care staff on duty were agency workers, only some of whom were familiar with the service and the needs of people living there. On the second and third days of the inspection, two permanent care staff were on shift, supported by agency staff and one senior member of staff. This meant that people were frequently supported by staff who were unfamiliar with their needs.
- Staff were very busy, and people's basic needs were not met in a timely way. They had to wait for long periods to receive basic care, such as support with personal care, going to the toilet, support to eat or to be made comfortable. Staff had no time to chat with people. People cared for in their rooms and in communal areas of the home were left isolated.
- There were some night shifts during which there were no permanent staff and therefore no staff trained to administer medicines. This meant people would have to wait for senior staff to travel into the service to administer medicines if they were required during the night. This included where people might have required pain relief.

The provider had not ensured there were enough staff deployed throughout the home to ensure people's care and support needs were met safely. This was a continued breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection and the urgent action we took, the provider increased the number of staff on shift and took steps to ensure that every shift was supported by permanent staff alongside agency staff. They also

took steps to ensure there was a member of staff on every shift who was assessed as competent to administer medicines.

● The provider had a system in place to support them to carry out pre-employment checks to help them to make safe recruitment decisions. However, we found this system had not been used effectively to ensure references provided were from the most recent employer, or to ensure all gaps in employment had been scrutinised. This increased the risk of people being supported by staff who were not suitable to the role.

This was a breach of Regulation 19 (Fit and Proper Persons Employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager and the managing director told us that recruitment was ongoing to try to increase the number of permanent staff available on every shift.

Using Medicines Safely
● Medicines were not managed safely. Staff were administering medicine for one person's condition as a 'delegated responsibility'. This is where staff have been trained to administer medicine that can usually only be administered by a nurse. This responsibility is then overseen by the district nurse team. We found multiple areas of concern that demonstrated this person was not supported to take their medicines safely. This included gaps and erratic times in administration. Records indicated the person's condition was not under control, with no reference to any action taken. There was no copy of the person's prescription on site and the medicine was not included in their pharmacy Medicine Administration Record (MAR). Therefore, it was not possible to verify whether the doses administered were as prescribed. Despite repeated requests, no evidence was provided that staff had received training and had their competency regularly assessed to administer this medicine, or that the district nursing team had any oversight in relation to this administration.
● Topical medicines, such as creams, were not managed or stored safely. We found these in the office and outside a bathroom. We also found creams in bedrooms with the name torn off the prescription label, as well as creams prescribed for other people in people's bedrooms.
● Medicines administration was not carried out safely. We observed staff entering people's rooms with medicines for other people as well as medicines intended for them. This increased the risk of administration errors.
● A review of MAR charts identified multiple issues including incorrect stock counts, missing signatures and the incorrect recording of the prescribed dosage. We found that, where there was a clearly stated minimum interval between doses, this was not always observed.
●Where people were prescribed medicines on an as and when required (PRN) basis, guidance to staff on how and when these should be administered was not in place. This included medicines such as morphine for pain relief and a medication for topical application in the event of an emergency.

People were put at risk of harm because their medicines were not managed safely. 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 first day of the inspection, the provider handed back to the district nursing team the responsibility for administering the medicine previously delegated to staff.

Assessing risk, safety monitoring and management
● Information in care plans and risk assessments was sometimes incomplete or not consistent which put

people at risk of receiving unsafe or inappropriate care. For example, one person who had a history of seizures had no care plan or risk assessment in place in relation to this. Another person at high risk of falls who was prescribed blood thinners, had no risk assessment in place for this.

● People were not protected from the risk of pressure damage. We found insufficient information in care plans in relation to pressure relieving equipment and measures in place to reduce risk. We found pressure relieving mattresses for four people at very high risk of pressure damage were set incorrectly for the person's weight. This increased the risk of pressure damage because they were lying on a mattress that was not relieving pressure effectively, and in some instances may have worsened the risk of pressure damage by being too rigid.

● Staff did not follow the guidance within care plans and risk assessments to ensure people's needs were met safely. Where people were to be repositioned in bed every two hours to reduce the risk of pressure damage occurring or worsening, records indicated this did not always happen. We found multiple occasions where people were left for three or four hours. One person who had pressure damage was left for sometimes as much as nine or ten hours. Two people had pressure damage at the time of the inspection and a third person had worsening pressure damage that, by the last day of the site visit, resulted in them needing to be cared for in bed.

● People were not supported to safely manage their continence needs. Catheter care for one person was not carried out safely, resulting in their catheter becoming overfull and them being left wet in bed. This would likely have been very uncomfortable for the person, and put their skin integrity at further risk, particularly as they already had pressure damage. On the second day of the inspection, two people were left without support to go to the toilet. This went unnoticed until a visiting professional sought out staff to tell them that the two people were sitting in the lounge in wet clothing.

● People were not protected from the risk of harm because fire doors were propped open. One person's fire door had been removed and not replaced, which meant they were not protected in the event of a fire.

People were put at risk of harm because the provider had failed to robustly assess, monitor and act on risks relating to the health safety and welfare of people. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the provider carried out pressure care refresher training for staff and placed stickers on people's beds showing the correct mattress setting for that individual.

Since a recent inspection by the fire safety officer where significant shortfalls were found in relation to fire safety at the service, the provider was taking steps to address these issues.

Preventing and controlling infection

● Before this inspection, the environmental health officer had identified serious concerns in relation to the cleanliness of the kitchen, evidence of the presence of rodents and poor food safety practices within the service. This had resulted in the temporary closure of the kitchen to allow for deep cleaning and for steps to be taken to address poor practice and make the required improvements. During our inspection, we found the kitchen was clean.

● The standard of cleanliness within the rest of the home was poor and there was a malodour throughout the ground floor of the building on all three days of inspection. Carpets in communal areas were not clean. A Relative told us, "The home does have a smell of urine. The smell is mostly in the corridors. The place doesn't have a homely feel."

● The area for staff to put on and take off Personal Protective Equipment (PPE) was small and untidy and not kept clean which increased the risk of the spread of infection.

● Clinical waste and disposal of sharps was not being managed safely. On the first day of the inspection we found a soiled continence pad left in a ground floor toilet for several hours. A clinical waste bag was left

outside the property on the ground next to the bins rather than safely inside a clinical waste bin. This was addressed quickly by the registered manager when we brought it to their attention. A sharps box containing sharps was found on the office floor. This put people at risk of injury and infection. There was a large number of sharps boxes in the medicines room, indicating that sharps disposal was not effectively managed in the service.

The provider had failed to assess, prevent and control risks associated with infection. This was a breach of Regulation 12 (Safe Care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were somewhat assured that the provider was using PPE effectively and safely. However, we noted that one agency worker did not wear correct PPE when supporting people to eat.
● We were assured that the provider was admitting people safely to the service.

Visiting in care homes
● People and their relatives did not report any concerns about the visiting arrangements in place at the home, and we saw some people received visitors during the days of our inspection.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● People were not protected from the risk of avoidable harm. Systems and processes in the service had not been used effectively to identify where poor care put people at risk of harm.
● Safeguarding concerns identified during this inspection had not been identified or acted on by the provider or the registered manager. This included shortfalls in care that may have contributed to the development or the worsening of pressure damage, poor support in relation to nutrition, hydration and the management of a medical condition. We have raised these concerns with the local authority who have lead responsibility for safeguarding matters.
● Where shortfalls in safety had been identified, these were not always learned from and addressed to avoid things going wrong in the future. For example, it had been raised in a staff meeting that people were not always receiving the required amount of fluid. However, following this, records indicated this continued to happen and no further action was taken.

People were not protected from the risk of avoidable harm. This was a breach of Regulation 13 (Safeguarding Service Users from Abuse and Improper Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Inadequate

Is the service effective?

Our findings

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

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

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

- Mealtimes were not evenly spaced throughout the day. On the first day of the inspection, lunch was served to people who were able to eat independently at 1.50pm and the evening meal was served at 4.30pm, just over two and a half hours later. This may have resulted in people eating less at 4.30pm because they were still full up from lunch. There were multiple occasions where people at very high risk of weight loss went without food for long periods. For example, one person who was assessed as being at very high risk of weight loss had lunch at 1.28pm and was offered their final meal for the day at 4.28pm, of which they ate only a little. They were then not offered anything else to eat until breakfast the next day at 10.09am. A second person who had lost significant weight over the last 12 months frequently went for 18 hours from the last meal of one day and breakfast the following morning.
- Where people's care plans indicated the need for additional high calorie snacks and drinks and that alternatives were to be offered when food was refused, this was not always followed.
- The fluid intake target amounts identified in people's care plans were frequently not reached. For example, one person assessed to require 1500mls per day was, on one occasion, offered 450ml and had an actual intake of 115mls.
- The mealtime experience was poor. People were left waiting for long periods with no explanation of why meals were delayed. Some people were observed to be distressed by this. Several people told us they were not happy with the quality of the food and said they were never offered condiments at mealtimes. Everyone we spoke with told us they did not know in advance what food they would be eating, until it arrived.
- The support provided to people at mealtimes was poor. A member of staff gave one person their plate of food when they were sitting in an armchair. They had no cutlery, no table and they could not balance to stand up to get the cutlery for themselves without dropping the food. Staff assisting people to eat, did so in silence, offering no encouragement or conversation. Food for one person requiring support to eat was left for over 40 minutes. It would not have been appetising to eat at that point. This would not encourage good food intake.
- Kitchen staff did not have good understanding of how to meet people's specific dietary requirements relating to medical conditions such as diabetes. They did have good understanding of people's requirements in relation to different consistencies, such as pureed or soft diets and thickened fluids. However, we found records indicated that people had been offered food that was not suitable for their assessed needs. For example, one person who was on a pureed diet had been offered biscuits. This placed them at risk of choking.

People were not protected from the risk of weight loss and dehydration. This was a breach of Regulation 14

(Meeting Nutritional and Hydration Needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

● Some relatives felt that permanent, experienced staff had good skills although others did not agree. One relative said, "I don't think staff have the skills needed. [Family member] has [medical condition] and is taken to hospital every time. It would be good if a member of staff knew how to deal with it."

● Most relatives felt that newer staff and agency staff were less able than experienced staff to carry out their roles well. We found agency staff did not demonstrate they had the skills to care for people safely. For example, when one person was found on the floor, they did not know how to check them over and reposition them safely to a chair. The registered manager had to provide step by step guidance to them on how to do this.

●Many relatives felt that staff skills in relation to dementia care were not strong. One relative said, "I don't think they have the skills to work with vascular dementia." We observed that some staff on shift did not have sufficient skills and knowledge in relation to person centred care or engagement.

● Permanent staff said they received sufficient training to carry out their duties, but also said they felt the quality of online training was not as good as face to face training they had previously enjoyed. We found there were gaps in staff knowledge that had an impact on the care provided to people. For example, in relation to pressure care. Although staff trained in medicines administration had their competency assessed, we found that they did not always follow safe medicines administration practice.

● We were told that new staff completed an induction which included shadowing experienced staff before working unsupervised. However, we found a new member of staff was working their first shadow shift on the first day of the inspection, when there were no permanent staff on shift.

The provider had not ensured that there were sufficiently skilled and trained staff on shift at all times. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the provider told us that pressure care and manual handling refresher training for all staff, including agency staff was being carried out. They also told us of their intention to include agency staff in other training events in future.

Adapting service design, decoration to meet people's needs

● The Premises were not clean or maintained to a suitable standard and did not meet the needs of people living at the service. The decorative condition of some bedrooms and communal areas was poor and in need of cleaning and redecoration. Many bedrooms were sparse and not personalised to support people to feel comfortable and to have familiar belongings with them.

● There were few measures in place to support people who were living with dementia to find their way around the premises.

● Staff practice in relation to the premises was not effective or safe. On the first day of the inspection fire doors to bedrooms were propped open and some doors had no fire guard. Bed breaks were not applied on two beds we looked at which put people at risk of falling if they were to attempt to get into bed.

● There was no call bell in some bedrooms that were occupied, leaving people with no means to alert staff. One person said they had been told to tap their foot on the sensor mat to alert staff. However, it was not positioned closely enough to where they were sitting, resulting in them needing to stretch their leg to reach it. This put them at risk of falling. Another person's sensor mat was positioned under the bed, so would not have alerted staff in the event that they fell out of bed.

The lack of cleanliness and maintenance of the premises and incorrect use of equipment was a breach of Regulation 15 (Premises and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

●People were not supported to maintain a healthy lifestyle and the service did not work well in partnership with other health and social care professionals to ensure effective care was provided. Where people required input from external professionals, such as speech and language therapists, , dietitians and district nursing teams, there was not always evidence to show that referrals had been made or followed up, or that guidance received was followed.

● Where one person had lost a significant amount of weight over the last year, despite requests, there was no evidence provided to us that input from the relevant professionals had been sought.

● Despite repeated requests, evidence of district nursing input to people with nursing needs and oversight of delegated tasks was not provided.

● Systems to ensure any information from visiting professionals was shared and used to update care plans were not used effectively.

● The lack of effective information sharing between the service and the hospital had resulted in one person's surgery being delayed because the home had not stopped the person's medication prior to their appointment.

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

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

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

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

● Where people had DoLS authorisations, these were not always reapplied for in a timely way to ensure this was done before they ran out.

● Mental capacity assessments were completed when it was appropriate to do so. However, the records did not always demonstrate how the person was involved in the decision or what steps had been taken to help them understand the decision being considered.

● People were not always asked for their consent before care was provided. This tended to happen when they were supported by permanent staff, but not consistently when supported by agency staff. One relative said, "They (staff) just get on with it. Perhaps they'll say, shall we take you for a shower. Consent is not always asked for." However, staff told us they would always respect people's right to refuse care.

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

● Initial assessments were completed before people came to live at the home, however these were not

always used to develop care plans and risk assessments in a timely way to ensure people received appropriate care. For example, one person was admitted to the home on 22 August 2022, but at the third day of inspection on 07 September, they did not have risk assessments in place in relation to known areas of high risk.

● There was no evidence to show the initial assessment process had been used to consider whether the service had capacity to meet the needs of both current people and the person being assessed.

Inadequate

Is the service caring?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

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

- People's dignity and privacy were not protected, and they were not always treated with respect. There were times when staff were not as caring as they should have been. For example, one person had socks put on their feet that were much too small and staff did not respond in a timely way to remove them. This had caused them pain and when the socks were removed their feet were discoloured, deeply ridged and cold. Agency staff supporting them did not make any comment about this and just walked away. Some relatives said they felt there was a lack of commitment and concern from some staff in relation to people's wellbeing.
- Many agency staff did not engage with people beyond providing physical care. One relative said, " [Staff] bring tea and food to the common room but just stand about and observe. Two people with dementia kept saying they were cold. No one listened. I asked the [staff] to bring cardigans and blankets. They could ask people what they'd like to watch on T.V or bring magazines for people. I did it." Another relative said, "[Family member] gets physical care, but emotional care is poor."
- During the inspection, we observed that staff were not visible in the service, did not initiate conversations with people, speaking in an abrupt manner, such as telling people to, "Come this way", "Sit there", "Stand up" and, "Wait a minute." Staff, including management, referred to people who required support to eat as 'the supports' and 'the assists'. This was not respectful language and did not promote the message that people were valued.
- We noted that permanent staff engaged much more positively with people and tried to have some fun and friendly exchanges with people while carrying out care tasks. However, they did not have time to provide the emotional support and engagement people required to promote their wellbeing. They were very aware of this and said they tried their best, but they did not have time to do their job in the way they wanted to. They also did not have time to respond quickly to people's physical needs. For example, one person who was in pain requested a pillow to put behind their back. The member of staff spoke kindly and agreed to fetch one for them. However, the person then waited for an hour and a half to receive the pillow.
- People were left in wet clothing and only received support with personal care when a visiting professional alerted staff to this. Relatives spoke of family members waiting a long time for continence support and of support that was not dignified, such as their relative being told to soil their pad when they requested assistance to use the toilet. After meals we observed that people were left with food down the front of their clothing. This did not uphold their dignity or show consideration for people's comfort.
- On several occasions over the three days of the inspection, we observed one person was walking in communal corridors dressed only in underwear. Another person told us they had been left naked, sitting in their bedroom waiting for care. They had then chosen to try to wash and dress themselves because support

had not arrived. Relatives told us that people did not always receive adequate support to wash as often as they would like. One relative said, "[Family member's] hair can be filthy and greasy. I had to wipe [their] eyes clean…They (staff) don't have the time."

● Relatives confirmed that people's bedroom and toilet doors were closed to offer privacy during personal care. However, on the third day of the inspection, we found that one person had been left without privacy because their bedroom door had been removed and not replaced for two days. The registered manager confirmed that the person would be supported to move to a different room until their door was replaced.

The provider had not ensured that staff provided compassionate care that upheld people's dignity. This was a breach of regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the provider confirmed they were taking steps to promote positive engagement in the service and to make clear their expectations in relation to compassionate care with all staff, including agency staff. They have also taken steps to increase the numbers of staff on shift.

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

● Permanent staff knew people and their preferences well. However, this was not the case with some agency staff, who did not appear to know people or to make any attempt to offer them choice in relation to their care. On all three days of the inspection, agency staff made up a high percentage of the staff on shift which meant that people were often supported by staff who did not know their needs and who did not take time to understand their preferences.

● Relatives gave mixed feedback about whether they were involved in decisions about their family member's care. Some relatives felt the service kept in contact and sought their views, whereas others felt they were not consulted.

Inadequate

Is the service responsive?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant services were not planned or delivered in ways that met people's needs.

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

● Care was task based, and frequently completed by staff with minimal engagement. Although care plans contained some personalised information about people's needs and preferences, staff did not always follow these when they provided care. For example, one person's care plan stated they liked to have music or the radio playing in their room and that they needed light as they were scared of the dark. During the inspection, they were in a dark bedroom with no radio or music. Another person liked music to be played, and their bedroom door left open, to enable them to watch what was going on in the home. On the first day of the inspection their bedroom door remained shut for most of the day and their radio was turned off.

● Inconsistent information within care plans did not promote person centred care. One person's care plan stated they required the support of two staff for personal care and required two hourly repositioning, then elsewhere stated they managed independently. Another person's care plan contained inconsistencies about what type of diet they required.

● People were cared for by staff who did not know them well. This led to entries in people's care notes that did not relate to them. For one person who was cared for in bed at all times, there was an entry stating that they had their meal in the conservatory on the first day of the inspection. We noted several entries in care notes referring to people by the incorrect gender.

● Many relatives we spoke with did not feel they had been meaningfully consulted about their family member's care needs or involved in reviews of their care. One relative confirmed they had discussions but said, "The discussions lack depth about [family member's] needs."

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

● People had nothing to do to keep them occupied or stimulated. People sitting in communal areas were not spoken to and, although televisions were on in both communal spaces, no one was watching them. People were sitting around the edges of each room, withdrawn and sleeping. On the first day of the inspection two people were sitting with their head in their hands. On all days of the inspection people were left for long periods without staff presence.

● People cared for in bed or who chose to remain in their rooms were isolated and again, many had nothing to occupy them or keep them company. One relative told us, "It seems to be more physical care, but they don't have time or skills for emotional care. [Family member] needs companionship and support to engage in activities, by people who know [them] and who [they] trust. [Family member] gets no stimulation." Another relative said, "The service is very functional" and "There is no social enrichment available."

Meeting people's communication needs

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

● Many people living at the service were living with dementia and had support needs in relation to communication. However, few attempts had been made to support people to communicate or to present information in a way that they might understand.
● There was a calendar board in the hallway, but this was showing the wrong date on two out of three of the days of inspection. Clocks in communal areas were showing the wrong time or had stopped. This did not support people to remain orientated to what time or day it was. A pictorial activities timetable was in place. However, none of the activities showing on it were being provided.
● Although menus were available for people to see what meals would be served that day, these were written rather than pictorial. We did not see staff using these at any time to explain what food was on offer for the day. On the first day of inspection, the menu on display did not show the meal that was served. The registered manager later confirmed to us that the incorrect menu had been displayed. They also told us that they had removed pictorial menus because they were frequently torn up. They had not, however, considered how they might replace them with sturdier copies that would support people to understand what meals were available.

End of life care and support
● The provider had an end of life policy in place which detailed how staff were expected to support people to plan ahead (where possible) to ensure care at the end of their life was in line with their wishes. It also detailed steps staff should take to provide emotional support, and how to ensure the person could be kept as comfortable as possible. However, the service was not following the provider's policy.
● Although end of life care plans were in place for some people, they were not sufficiently detailed to ensure they had a comfortable, dignified end to their life that took account of their personal wishes.
● One person was approaching the end of their life at the time of the inspection. Their care plan did not identify any steps to take to ensure the person's needs were met, simply stating that staff were to keep them comfortable. At the time of the inspection they had not been prescribed any 'just in case' medicines. These are medicines that are prescribed when a person is approaching the last days of their life and are used to reduce discomfort, such as nausea, pain, agitation or restlessness. The care plan did not detail any steps staff should take to provide emotional support or to consider the person's preferences. Over the three days of the inspection, the person was frequently alone, cared for in a silent room, attended by staff only when care tasks were required.

Care was not person centred. People's needs and preferences were not understood and met including in relation to end of life care. People were isolated and had no meaningful occupation to promote their mental wellbeing. These issues were a breach of Regulation 9 (Person -centred Care) of the health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●One relative told us that staff had used a tablet to show their family member videos related to their interests.
● Some relatives told us that they were supported to stay in contact with their family members by telephone and by social media when they had been unable to visit during the Covid-19 pandemic.

Improving care quality in response to complaints or concerns

●The provider had a policy and a system in place for managing complaints.

● Relatives knew how to raise concerns but gave mixed feedback about how this was used to make lasting improvements to the service. For example, one relative said they had raised concerns about the care provided to their family member at night. They said the issue was addressed and the situation improved, but within a few days, the poor care had resumed.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At the last inspection the provider was in breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the providers quality monitoring systems had not been used effectively to identify concerns found during the inspection. This included staffing levels, cleanliness, the timing of meals, lack of stimulation and occupation, and care that was not person-centred. At this inspection improvements to these issues had not been made and the provider was still in breach of this regulation.

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

- People did not experience positive outcomes and the provider's systems did not protect people from harm. Quality monitoring systems had not been used effectively to identify and address the issues identified at this inspection, many of which were unchanged since the last inspection.
- Staffing levels had not increased since the last inspection when it was found that there were not enough staff to meet people's needs. The registered manager told us that staffing levels continued to be calculated on a ratio of one staff to five people. This did not take account of the different support needs of people. This continued to have a significant impact on safety and the care people received.
- The failure to identify and act on unsafe medicines management and administration practice had put people at risk of harm because their condition was not being safely controlled, their medicines were not stored safely and they were not protected from the risk of the wrong medicines being given to them.
- The failure to identify and address incorrectly set pressure relieving equipment and significant lapses in repositioning for people who required it, put people at greater risk of pressure damage. In some instances, it was possible that these shortfalls had contributed to worsening pressure damage.
- Poor support to people at risk of weight loss or dehydration was not effectively identified and acted on. This put people at risk of harm.
- The registered manager's understanding of their role and responsibilities was not strong, and they demonstrated a lack of awareness of shortfalls in the quality of the service. The lack of effective leadership meant that person centred care was not promoted in the home. The culture of the service was task led and a good quality of life was not promoted. People's experiences, such as at meal times, and the lack of engagement were not identified as needing improvement.
- The provider and registered manager had a reactive rather than proactive approach to leading the service. This was highlighted by recent visits from the Environmental Health Officer (EHO) in relation to food safety and the Fire Safety Officer. Both of these visits identified significant shortfalls in safety at the service. Prior to

these visits, neither the registered manager or the provider had identified or addressed concerns in these areas. During the inspection, the registered manager told us that they would be able to make improvements now they knew what we wanted them to do. This demonstrated they were not proactive in their approach, but rather needed input from the regulators to identify shortfalls in quality and safety.

The failure to provide effective management oversight of the service or to take action to address previously identified concerns in the quality of care put people at risk of harm. This was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection we took urgent action to address the areas of extreme risk we found, The provider was initially slow to respond to our requirements. However, they have since taken action to increase staffing levels and developed a plan to support improvements to the service. The registered manager is being supported by the newly appointed operations director, who is driving improvements and supporting the registered manager to develop their skills going forward. The operations director has been open and transparent in discussions with us. They have demonstrated an understanding of the areas of concern and the work and time required to demonstrate lasting improvements.

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

● We received mixed feedback from family members about whether they felt they were kept informed when things went wrong. Some relatives told us the registered manager and staff kept them informed and contacted them if incidents, accidents or ill-health occurred. However, others felt this was not the case. They said that positive feedback received by telephone about their family member's wellbeing was not reflected in what they found when they visited.

Working in partnership with others

● Communication between the service and other professionals was not effective. The registered manager confirmed that it was sometimes difficult to have productive dialogue with other health and social care colleagues. However, they had not taken responsibility for addressing this with the professionals concerned. As a result, people's health outcomes were sometimes poor because responsibilities were not clearly defined between the care home and other healthcare services.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics;

● Relatives and staff mostly reported that the registered manager was visible within the service, approachable and listened to their views. However, some relatives did not feel the registered manager was proactive in making improvements in response to their feedback.

● No relatives we spoke with knew whether relatives meetings were held, and only three out of 16 relatives confirmed they had been formally asked for feedback at any time through a questionnaire or survey.

● We saw evidence that staff meetings took place and that the agenda for these was relevant to work and highlighted recent events in the service for discussion. Staff confirmed they felt able to speak up about concerns.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive person-centred care. Care plans were not followed and people's preferences were not observed. People were isolated and had no meaningful engagement or occupation

The enforcement action we took:

nop to cancel location and manager

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Staff did not always treat people with respect, or uphold their dignity and privacy

The enforcement action we took:

nop to cancel location and manager

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 provided with safe care in relation to assessing and managing risk, pressure care, medicines management, infection prevention and control and continence care.

The enforcement action we took:

We took action to cancel the the location and the registered manager. Before this, we took urgent action to impose conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider's systems and processes had not been used effectively to protect people from harm.

The enforcement action we took:

nop to cancel location and manager

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People were not protected from the risk of malnourishment and dehydration

The enforcement action we took:

nop to cancel location and manager

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premises were not clean or maintained to a suitable standard to meet the needs of people using the service. Equipment was not used effectively to support people's needs.

The enforcement action we took:

We took action to cancel the registration of the location and the registered manager.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not used quality monitoring systems to identify and address shortfalls in the quality of the service. Management oversight was poor.

The enforcement action we took:

We took action to cancel the registration of the location and the registered manager. Before this, we took urgent action to impose conditions on the provider's registration to restrict admissions to the home and to require the provider to take specific action to address areas of extreme risk identified at the service. We also required fortnightly updates on making improvements to be provided to us.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Pre employment checks were not always robustly carried out to ensure only people suitable to the role were employed.

The enforcement action we took:

We took action to cancel the registration of the location and the registered manager.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not used quality monitoring systems to identify and address shortfalls in the quality of the service. Management oversight was poor.

The enforcement action we took:

We took urgent action to impose conditions on the provider's registration to restrict admissions to the home and to require the provider to take specific action to address areas of extreme risk identified at the service. We also required fortnightly updates on making improvements to be provided to us.