BSR London Limited

Chesterholm Lodge

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Chesterholm Lodge is a residential care home that provides accommodation for older people and adults living with a mental health condition. The service is registered to accommodate up to 15 people. At the time of our inspection, there were 15 people living at the service.

People's experience of using this service and what we found
People did not receive a service that provided them with safe, effective, compassionate and high-quality care. The staffing levels were not sufficient to keep people safe and provide them with effective care to meet their needs. Risks to people's safety and well-being were not managed effectively, placing people at risk of harm and environmental risks had not always been considered or acted upon.

People were not always safeguarded from abuse and incidents and accidents were not managed safely to prevent a reoccurrence. The management of medicines was unsafe, and people did not always receive medicines as required.

The environment was not well maintained and did not promote people's emotional wellbeing or physical safety. Staff did not complete training in meeting people's needs and this meant people were at risk of inappropriate care and treatment.

People were not always provided with a varied and nutritious diet based on their individual preferences and could not always access food as required.

The principles of the Mental Capacity Act 2005 were not understood and applied. 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; the policies and systems in the service did not support this practice.

Staff were described as kind and caring, and we observed people were spoken to in a respectful way. However due to the environment people did not always receive care that promoted their privacy and dignity.

Leadership was poor and the service was not well-led. Governance systems were ineffective and did not identify the risks to the health, safety and well-being of people or actions for continuous improvements.

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

Rating at last inspection
The service was rated as Good at the last full comprehensive inspection, the report was published in April 2019.

Why we inspected
The inspection was prompted in part due to concerns received about insufficient staffing levels to meet peoples needs, the safety of the environment and the overall management of the service. A decision was made for us to inspect and examine those risks.

The overall rating for the service has changed from Good to Inadequate. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvement.

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

Enforcement
We have identified the following breaches at this inspection.

Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider failed to ensure sufficient staff were deployed to meet people's needs at all times.

Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to ensure risks relating to the safety and welfare of people using the service were assessed and managed.

Regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider failed to safeguard people from abuse and improper treatment.

Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider failed to ensure the environment was properly maintained.

Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider failed to ensure people's rights were upheld within the basic principles of the Mental Capacity Act 2005.

Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider failed to operate effective systems to assess, monitor and improve the service.

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

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

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

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

Following our inspection, we raised our concerns about people's safety with the local authority safeguarding team.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Chesterholm Lodge

Detailed findings

Background to this inspection

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

Inspection team
This inspection was conducted by three inspectors.

Service and service type
Chesterholm Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

At the time of the inspection the service did not have a manager registered with the Care Quality Commission. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager left the service on the 27 September 2019. On day three of the inspection a new manager was in place who commenced working at the service on the 25 November 2019.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
Before the inspection we reviewed information, we had received about the service, including previous inspection reports and notifications. Notifications are information about specific important events the service is legally required to send to us. We also considered information the provider sent us in the provider information return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information we had received from the local authority, safeguarding team, healthcare professionals

and whistle-blowers. We used all of this information to plan our inspection.

During the inspection
We spoke with eight people who used the service about their experience of the care provided. We spoke with 12 members of staff including, the nominated individual, two directors of the providers company, the manager, the activities coordinator, the cook, the housekeeper and five members of the care staff. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We observed the care being provided and reviewed a range of records, included seven people's care records and multiple medication records. We looked at staff files in relation to recruitment and training and a variety of records relating to the management of the service including, audits and policies and procedures.

After the inspection
We continued to seek clarification from the provider to validate evidence found and reviewed training data, quality assurance records and additional supporting information provided by 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 the last inspection this key question was rated as Required Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

- Prior to the inspection issues in relation to the staffing levels had been brought to the attention of CQC. This was reported to the nominated individual who responded, 'all shifts are being filled with the correct ratio, I am personally responsible for this.' However, they were unable to provide us with details of how 'correct ratios' had been established. This was discussed on day one of the inspection with the nominated individual and provider who told us staffing levels had not changed for a number of years and had always been deemed as appropriate. They were not able to demonstrate that staffing levels and people's needs had been appropriately assessed and reviewed to ensure staffing levels were sufficient.
- The nominated individual told us following the concerns raised with them about staffing levels this was discussed with staff who brought it to their attention that some people's needs had increased. This had resulted in the nominated individual requesting additional support from the local authority. However, they had not taken action to mitigate staffing issues in the meantime.
- People living at the home had varied needs and abilities. Some people required support with washing and dressing and others needed ongoing emotional, social and psychological support. The staffing levels were not sufficient to keep people safe and provide them with effective care to meet their needs. Staff were observed to not have the time they required to provide people with responsive and effective care in a relaxed and person-centred way.
- Prior to the inspection the nominated Individual provided us with information about staffing levels on a 'typical weekday' via email. The information they provided stated the following; 'morning shift, 7.30 to 14:00; two care staff, one manager, one kitchen staff, one housekeeper, one administrator and one maintenance staff. Afternoon shift, 14.00 to 21:00; two care staff and one manager.' However, daily staff signing in sheets provided at the inspection demonstrated there had only been management cover for one week since the previous registered manager left the service in September 2019, there had been no administration cover for the last two weeks and a maintenance person was currently not employed by the service. Maintenance provision was being completed by the provider on an adhoc basis. This demonstrated the staffing information provided by the nominated individual did not reflect the staff deployed at the service and was not accurate. There had been no manager in place to provide oversight of the service and staffing levels were insufficient to meet people's needs.
- The staff signing in sheets also highlighted on some days only two care staff were available throughout the day and night. This meant that as well as providing people with personal care and emotional support, staff were required to cook and prepare all food and fluids, clean, complete administration tasks and administer medication. Other days showed that in addition to these two staff, a cook may be available for three hours in a day only.
- On day one of the inspection we heard a person become distressed upstairs in what appeared to be an

altercation with another person living at the home, however no staff were available to support these people as they were busy completing other tasks. Another person asked us for a cup of tea and some toast and this was brought to the attention of a staff member, however this had still not been provided one hour later.

● Some of the people spoken with described there not being enough staff available to provide them with the care they required. A person said, "The staff are kind, but can be slow sometimes. If I need them in a hurry I bang on the table." Another person told us, "I think they are definitely short staffed." A third person said, "I often have to wait for up to two hours for my medicine."

● Health and social care professionals also provided us with feedback about staffing levels. A healthcare professional said, "I think it's curious how anyone can think there is enough staff. (Name of person) has very high needs and there is usually only one staff member on the shop floor." Other health and social care professionals told us they were reviewing some people's needs as they were concerned staffing levels were not appropriate to meet these people's needs effectively.

● All staff spoken with felt there was not enough of them to meet people's needs. A staff member said, "There is not enough staff at the moment, people's needs have increased but the staffing levels haven't." Another staff member told us, "Weekends are really hard, there isn't always a cook and if there is they are here for 3 hours on a Sunday, the rest of the time there are just two of us, [carers]. We don't have the time to do the medicine properly as people need us to help them. We have to cook dinner, breakfast and tea, answer the phone, do the laundry, do paperwork and give people the help they need. We don't have time." A third staff member told us, "I have to tell people I can't help them with a bath or shower as I have to cook dinner. I can't keep to what people want."

● The above issues were discussed with the providers and nominated individual on day one of the inspection. They agreed to increase the staffing levels in the home and provided us with staff rotas to reflect the increase of staff. However, these rotas did not demonstrate that staffing levels had been increased sufficiently to ensure people's needs could be met safety and effectively. On day three of the inspection this was discussed again, when the providers agreed to increase the staffing levels at weekends.

The failure to ensure sufficient staff were deployed to meet people's needs at all times was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Safe recruitment practices had been followed. This included a range of pre-employment checks and checks with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable people.

Assessing risk, safety monitoring and management

● Risks were not always managed and mitigated effectively.

● Although most people told us they felt safe we found that not all people's care plans and risk assessments contained detailed information and clear guidance to staff about how people's needs should be met to mitigate risks. For example, one person experienced breathing difficulties, yet a risk assessment for the management of this was not in place. This meant no guidance was available to staff of what actions they should take if this person's breathing became compromised.

● One person's risk assessment in relation to nutrition, completed on 3 September 2019, stated that they were to be 'weighed monthly.' However, this person had not been weighed at the time of the completed risk assessment or thereafter. This was brought to the attention of the nominated individual and the provider on day one of the inspection. On day two of the inspection we were told by the provider that all people had now been weighed however, this person had declined. We were also told people's new weights had been compared to their previous weights and no one living at the home had lost weight. However, when this was reviewed by the inspector it was found that one person had lost, 23.5kg in the last nine months. This had not been addressed or acknowledged by the nominated individual or provider and no actions were planned to

investigate this.
● There were a number of environmental risks highlighted at the inspection.
● Portable heaters were used in the lounge. However, there were no risk assessments in place for these. This had been highlighted at the last fire inspection which had been completed in February 2019 and was included in the fire inspection report, yet no action had been taken to address this risk. These had been removed by day three of the inspection.
● Electrical sockets were overloaded. This had been highlighted at the last fire inspection which had been completed in February 2019 and was included in the fire inspection report, yet no action had been taken to address this risk.
● Staff had not received fire safety training. The last fire alarm check was completed two weeks prior to the inspection by a staff member. The nominated individual confirmed this should be completed weekly. They told us this had not been competed as the staff member who completes these checks had not been in the service. Additionally, the last fire evacuation drill was recorded as taking place in March 2016. The nominated individual was unable to provide us with evidence that a more recent drill had been completed.
● There was clear evidence some people living at the home smoked in their rooms. Although there were risk assessments in place for this, these were not always followed. This meant risks were not being mitigated or managed effectively placing people at risk of harm.
● Some people's bedrooms posed significate health, safety and fire risks. For example, one bedroom had clothes, bedding, cigarette stubs and burn marks all over the floor. There was also mouldy food in this room. This was brought to the attention of the provider, nominated individual and staff who all told us this person refused to let staff enter their room support them to tidy up. Continuing to leave a person's room in this condition posed a serious risk to all people living in the homes.
● Water temperature checks had not been completed in accordance with legionella risk assessment since August 2018. This was discussed with the provider who told us they thought because they sent off a water sample for legionella they did not need to record water temperatures. We advised that all water outlets (taps) should be tested, and temperatures recorded monthly. The provider told us he would address this issue and carry out monthly water temperature testing.
● There was no provision in place to allow staff to monitor people leaving or entering the home. There was a number of access points which were not alarmed or secure. One person was under a Deprivation of Liberty Safeguard (DoLS), which meant they had been assessed by the local authority as unable to go out of the service without being accompanied by staff for their safety. However, due to lack of provision this person could leave the home undetected. This was discussed with the provider and nominated individual on day one of the inspection who said the person had never left the service or attempted to leave. The director agreed to place alarms on these doors. Door alarms were in place by day three of the inspection.

The failure to ensure people were provided with safe care and treatment was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● The management of medicines was unsafe.
● There was a not a robust system in place for ensuring medicines were ordered in a timely way. This task used to be completed by the registered manager of the service however, when they left in September 2019 this responsibility was not delegated to another staff member. Care staff had taken on this task however, they were not confident of the process and had not received up to date medicine training.
● There was no record of the medicine stock on site for those dispensed from boxed or bottled containers. It was not possible to monitor these medicines and identify and investigate any concerns. There was a risk people's medicine could be missing or run out, resulting in people not having access to the medicines they required. One person told us the service had run out of their pain medicine three days prior to the inspection

and they were still waiting for this to be delivered. This meant if the person experienced pain, they would be unable to received medicines to relieve it. The lack of prescribed pain medicine for this person was discussed with a staff member who confirmed the person had not had access to this medicine for three days.

● Some people living at the home were prescribed 'as required' (PRN) medicines, such as pain relief and medicines to help with agitation. However, people told us they could not always access these medicines when required. One person said, "I get my medicine when I need it, except at night. I occasionally need medicine at night, like a pain killer or anti-psychotic but I can't get them." Another person told us, "No, I can't get medicine at night. The last time I get medicine is about nine to ten o'clock, (pm) but can't get anything after that. They (staff) tell me they don't have the keys." A third person said, "Sometimes I can get medication at night, but not always. It depends what staff are working. If its agency or (name of staff member) I can't get any because they aren't trained.

● There was excess stock of medicines that have legal controls, 'Controlled drugs.' This was discussed with a staff member who informed us these medicines had not been returned as staff had not had the time to do this. The system in place to manage people's medicines was not effective to ensure they were accounted for safely.

● Medicines were stored safely in a locked trolley and storage temperatures were checked to monitor they were kept at the appropriate level.

The failure to protect people from the risks associated with the unsafe management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

Preventing and controlling infection

● Measures in place to assess the risk and prevent the spread of infections were not effective.

● Not all staff had received appropriate infection control training.

● There was very limited stocks of gloves and aprons in the home and staff told us they often ran out. We spoke to providers who told us they ordered this on an as required basis.

● There were very limited cleaning materials available to staff. Staff told us they often ran out of cleaning products.

● People's beds and mattresses were broken and stained. A number of beds did not have any sheets on. Bedding that was in place was stained, of poor quality and ripped. Some beds had been made with dirty sheets.

● Three arm chairs in the lounge were in a poor state of repair, some had holes in the fabric with sponge exposed and were dirty and stained. This is an infection risk. This was discussed with the provider on day one of the inspection who said this had already been identified was going to be addressed. On day two of the inspection we noted that tape had been stuck on the area of concern on one of these arm chairs.

The failure to protect people from the risks associated with the spread of infections was a breach of Regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● Some practices in the service were restrictive, this placed people at risk of institutional abuse. For example; people were not always able to access food when required. This was because some communal food was locked away and could not be accessed by people or staff. This meant people could not have freedom of access to snacks and food if they chose to do so.

● A person said, "Tea time is at 5pm, if I wanted anything at 9pm it wouldn't be provided. They don't have anything anyway, we run out of teabags, milk, Weetabix and bread, it happens regularly." A number of people told us they would buy additional food themselves, however we saw evidence that one person was

unable to access the food they had brought at a weekend as this had been locked away. Staff on shift did not always have access to keys for the locked away food, this was particularly evident at weekends.
● A person was unable to access their bank card for three days, which they wanted to allow them to do some shopping. The person's bank card had been locked in the service safe, there was no record or information about why this person's bank card had been locked away. The staff on shift did not have the access code for this safe. A staff member said, "It's not right [name of person] couldn't access their bank card at the weekend, but we couldn't get it for them as the owners won't give us the safe code."
● Not all staff had completed training in safeguarding adults from abuse. When safeguarding issues were discussed with staff they were able to demonstrate they understood how to recognise abuse and the action to take if they had concerns. However, no one appeared to have recognised the institutional approach and restrictive practices in place as abusive.
● The above concerns were discussed at length with the providers and nominated individual who agreed to ensure people and staff could access what they required.
● We were not assured that all incidents which could constitute a safeguarding alert or concern were being identified by the service. This was because the system to review and monitor incidents was not effective.
● On day three of the inspection safeguarding processes were discussed with the manager of the service, who had taken up post the day prior to day three of the inspection. The manager had a clear understanding of what actions they would take to ensure people using the service were safeguarded against abuse.

The failure to safeguard people from abuse and improper treatment is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● The provider did not have a robust system in place to monitor accidents and incidents, or to identify any patterns or trends. Although incidents and accidents were recorded and logged there was no evidence any investigations had taken place, analysis of why these incidents may have occurred or that measures had been implemented to reduce the likelihood of this happening again.

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 the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- The provider's training records showed that staff had not received adequate training in a timely way to equip them to do their roles, safely and effectively.
- Staff training records showed of the 10 staff employed, two staff had not received medicine training, these two staff members were on shift together on day one of the inspection and were administering medication; another two staff members had not had their medicine training updated in a timely way. Additionally, five staff members did not have up to date safeguarding training; four staff members did not have fire awareness training; two staff members did not have up to date infection control training; six staff members did not have up to date moving and handling training and three staff did not have up to date infection control training. Furthermore, four staff members did not have up to date food hygiene training however, they were required to prepare meals for people.
- Lack of staff training was discussed with the provider and nominated individual on day one of the inspection. They told us all staff had received effective training in a timely way. We gave them five days to provide us with evidence of this however, this was not received, and they told us that as the training had since been updated no record of previous training was available. Therefore, we could not be assured staff had received training.
- On reviewing the service's training policy, training was not provided in accordance with this policy.
- Between day one and day two of the inspection some staff completed required training via eLearning. The training staff had completed, included medicine training. However, following eLearning training in this area, staff competency was not checked robustly to ensure the learning was understood and staff were now competent to administer medicines safely. A staff member said, "I have done medicine training now, but I'm not confident."
- Staff had not completed training in supporting people specific needs, for example those people with complex mental health needs, hoarding behaviours, alcohol dependence and dementia, diabetes, end of life care and falls. We found that people with these needs were not always supported safely.
- The concerns around the lack of training provided to staff were raised with the providers and nominated individual who agreed to review the current training provided to staff. The nominated individual also confirmed they would ensure staff would complete essential training, including infection control, medication management and fire safety.
- Staff told us they last received one to one supervision with the (previous) registered manager in September 2019 before they left. Staff were unsure of the supervision arrangements since the departure of the registered manager. Staff told us at this time they felt unsupported, not listened to and undervalued by the providers. They also said that concerns they had brought to their attention were not always acted upon.

The failure to ensure staff received appropriate training was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● New staff completed an induction to the service and a probation period before being permitted to work unsupervised. A new staff member confirmed they completed an induction.

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

● The environment was not well maintained and did not promote people's emotional wellbeing or physical safety. Some people's bedrooms were in a poor state of repair and unsafe for people. For example, one person's room was unkempt with evidence of hoarding. Although staff told us it was the person's choice to live this way their life choices placed everyone else living at the home at risk. Staff had not taken actions to address this issue and wider risks to others had not been considered.

● A number of bedrooms viewed showed that people did not always have appropriate bedding, and for some, bedding in place was in a poor state of repair. For one person, their mattress was worn and required replacing. One person's bed was made with sheets that had cigarette burns in, yet this person did not smoke. Towels available for people to use were in a poor condition.

● Some areas of the home were cold. People also told us the home was cold. On day one of the inspection one person was sat in the lounge wrapped in a blanket. We checked the heating outlets in the communal areas of the home and found one was lukewarm to touch and the other appeared to not be on. This was discussed with the provider who told us the heating was on and disputed it was cold. They told us, staff and people opened doors and windows, which was the reason it was cold. They also told us staff could adjust the thermostat if they needed to. The provider then went on to say that a heating engineer visited the service on the 15 November to review the heating and a new part had been ordered.

● The premises had not been maintained or adapted to improve the quality of people's lives and living in an environment as described as above, would not have a positive impact on people's emotional, psychological and physical health.

● On day three of the inspection we found a number of actions had been taken to address the issues highlighted above. For example, new bedding and towels were in place, a new mattress had been ordered, the home was slightly warmer, and the provider had arranged for the radiators to be serviced. Additionally, the room that was unkempt had been decluttered and cleaned. We spoke to the person whose bedroom this was, and they were clearly pleased with the actions that had been taken.

The failure to ensure the environment was properly maintained was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some adaptations had been made to the home to meet the needs of people living there. For example, some corridors had handrails fitted to provide extra support to people and toilet bathroom and bedroom doors were sign posted, so that people could easily recognise them.

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

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA

application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● People's consent had been sought for their care needs. However, where people lacked capacity to consent to the care and support they required, the principles of MCA had not been followed, and best interest decisions had not been recorded.
● People who lacked capacity to consent to their medicines or their finances being managed by staff, did not have decision specific MCA assessments or best interest decisions recorded. One person, who was supported by staff to manage their finances, was unable to access their own bank card as it had been locked away by the provider. Staff told us they did not have access to this, which had meant that when the person had recently wanted to take some money out of their bank account, they were unable to do so. This was an unlawful restriction on the person as there were no records to demonstrate this action had been taken in the person's best interest. The provider could not demonstrate that the least restrictive options had been considered. We discussed this with the provider's representative and the manager, who assured us that they would complete relevant assessments for people's capacity and best interest decisions promptly.
● One person had a DoLS authorisation in place, however a mental capacity assessment had not been completed in relation to the person being under constant supervision and requiring support with their care and treatment.
● The provider and nominated individual demonstrated a lack of understanding of the legal framework, relevant consent and decision-making requirements of the MCA 2005 and associated best interest decisions. However, the manager was able to demonstrate a good level of knowledge and understood their responsibilities around the MCA. They told us they would take action to address the concerns we found.

The failure to ensure people's rights are upheld within the basic principles of the Mental Capacity Act 2005 is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● People were not supported to eat a varied and nutritious diet based on their individual preferences, which were detailed in their care plans. On arrival at the inspection on day one, when the inspectors explained to two people in the lounge who we were and what we were doing at the home. One of these people said, "I really hope you can help us with the food." These people went on to describe how they were not given enough to eat and food often, 'ran out.' Another person said, "There is hardly any food here, all we eat is chips and sandwiches." People's comments were further supported when inspectors viewed the content of the food stores and found very limited food stocks available. Furthermore, staff competed a comment book and on review of the entries in this book it was noted comments included; 'Not enough bread for lunch', 'Not enough eggs- very small portions given', 'No yoghurts and swiss role for lunchtime', 'Staff had to bring in extra vegetables, garlic bread and macaroni as per menu', 'only 12 services of Angel delight for 14 people', 'No sugar, very limited teabags, no porridge, no pudding for lunch, only quarter litre of milk.' These entries were made from the 9 to 18 November 2019.
● The limited food stocks were discussed with the provider and nominated individual on day one of the inspection who told us there was to be a food delivery the next day, and the service received a fresh food delivery three days per week.
● On the second day of the inspection more food was in place, however this was limited. For example, 12 people had requested tuna sandwiches for their tea; this was on the menu for that day however only three small tins of tuna were available in the kitchen. Furthermore, 300 grams of coffee had been purchased to

last one week for 15 people and additional day care residents. Fruit purchased consisted of 12 small bananas, and we saw eight pieces of breaded fish were available. When we asked a staff member why eight pieces of fish they said, "It's on the menu." We highlighted that there were currently 15 people living at the home and were told, "Well not all people would want it." This meant that even though we were told that people were given two choices at meal times it was possible some people may not have been able to receive their first choice option.

● This was discussed with the provider who was responsible for the food order, they told us, "Staff could always get more with petty cash." They added, "Someone must have taken some of the tuna that had been brought."

● On day three of the inspection we found food stocks had increased. However, a staff member told us, "I have never seen the larder look that full ever. It would be great if it lasts, I'm fed up with asking for the basics." Another staff member told us, "It won't last, when you have gone it will go back to normal."

● The availability of food for people was very tightly controlled by the providers. Food to be used was only accessed by 'key holders' including the providers and cook who were not always in the service. When they were not at the service they would make limited food provisions available for staff to use. This meant people's food choices were restricted.

● People's weights were not appropriately monitored if required to identify concerns in relation to weight loss. Evidence to support this comment can be viewed in the 'Safe' domain of this report.

● Although issues were noted with the provision and availably of the food, during all three days of the inspection the meals provided to people looked appetising and portion sizes were appropriate. However one person said of their meal at lunchtime, "We don't usually get this much." Another person told us on day three of the inspection their lunch was, "Terrific" and a third person said, "The meals are usually very good."

● People's specific dietary requirements were understood by staff and they were able to describe people's likes and dislikes. This information was documented in people's care plans.

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

● For people living at the service their needs had been assessed prior to moving into Chesterholm Lodge. However, since June 2019 people's needs had not been reviewed or comprehensively reassessed. This included when people's needs had changed. We could not be assured people were receiving appropriate and effective care.

● We could not see that policies in place were followed or based on up to date national guidance and best practice. This meant people's care and treatment may not always be delivered in line with the guidance and standards that support effective care.

● The providers and nominated individual lacked knowledge of how care should be delivered in line with standards, guidance and the law. For example, they lacked understanding of the MCA and how the restrictions they had put in place could be unlawful. Restrictive practices, MCA, need for assessments, standards of care and the law were all discussed with the manager on day three of the inspection who was able to demonstrate an in-depth knowledge of these areas.

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

● Peoples care records contained some information about their health needs, including information about people's general health and emotional needs. However, for more complex needs, including specific mental health conditions, such as schizophrenia or where people had a history of alcohol misuse; and physical needs such as breathing difficulties or the use of oxygen, there was not detailed and clear information for staff on how to best support people with these conditions. When these conditions were discussed with the providers and nominated individual they demonstrated they were unclear about people's needs and how these should be managed.

● People said they would be supported to access healthcare professionals when unwell. Care records confirmed people were seen by health professionals including doctors, specialist nurses, dentists and opticians.
● The service ensured that people received consistent and coordinated care if they were required to move between services; such as requiring a hospital stay. People would be sent with a 'hospital pack', which provided information about the person, including their needs, level of support they required and current concerns.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- Insufficient staffing levels and lack of staff training resulted in a negative impact on people. A healthcare professional told us, "(Name of person) is clearly unhappy here. In the last three to four months their behaviour has become increasingly challenging; this is how I know they are unhappy."
- Staff told us they felt the staffing levels resulted in them not being able to provide people with the standard of care they would like to give. Staff spoke of wanting to provide people with effective and high-quality care but felt unable to do this due to staffing levels. Staff told us they felt at times, they did not spend enough time with people due to completing other tasks and this impacted on them being able to always provide people with the level of emotional and physical support they needed. A staff member told us, "I'm certain people aren't getting the emotional and social support they need." Another staff member said, "We don't have time to talk to the service users, which is not good for their mental health. The services users have changed, we get all sorts of behaviours, I think it's because we don't have time for them."
- Some people living at the service appeared unkempt. A staff member told us they were unable to provide people with a bath or shower at the time they requested.
- Throughout the inspection we heard staff talk to people in a kind and respectful way and saw staff had built positive relationships with people.
- People told us the staff were kind. One person said, "The staff are kind" and another person told us, "They are very nice, they look after me well."
- Staff knew how people liked to be addressed and called people by their preferred name.
- People's protected characteristics under the Equalities Act 2010 were identified as part of their need's assessments. For example, we saw people's religious beliefs had been recognised.

Respecting and promoting people's privacy, dignity and independence

- During the inspection we saw that staff took steps to protect people privacy, such as knocking on their door before they entered and speaking with people quietly and discreetly about personal issues when in a communal area. Staff described how they took action to protect people's privacy when supporting them with personal care.
- On day one of the inspection it was observed some areas of the environment did not help support people's privacy and dignity. For example, there was no shower curtain in place within the bathroom and for one bedroom a shower curtain was being used to cover a patio door, this was ill fitting and did not maintain the persons privacy or dignity. This was discussed with the provider and nominated individual on day two of the inspection who told us, "There are plenty of shower curtains, staff must have forgotten to put them up." They added, "They are normally up." Additionally, on day one of the inspection it was noted by the

inspectors that a large amount of incontinence aids were in the window of a bedroom and these could be seen by passers-by. On day two of the inspection a shower curtain had been put in place. By day three of the inspection the incontinence aids had been removed and appropriate curtains had been fitted in the bedroom.

● The provider ensured people's information was kept confidential. People's information was stored securely at the office and staff had their own password logins to access electronic records.

● People were encouraged to be as independent as they could be both inside and outside of the service. However, it was not always identified when people required additional physical or emotional support.

● People's care plans provided information for staff about what people could do for themselves and where additional support may be required. However, these care plans were not always followed, and additional support was not always provided when needed.

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

● People were given the opportunity to express their views, by talking with staff. They also confirmed there had been residents meetings, however we were unable to establish the frequency of residents meetings. We requested the minutes of the last residents meeting and these were provided, although not dated, we were able to establish that the minutes provided were for the residents meeting completed in March 2019. These meeting minutes demonstrated discussions were held with people about the day to day running of the home and demonstrated that people were involved in making decisions about their care.

● From the meeting minutes provided we could not be assured people were regularly involved in making decisions about their care or the day to day running of the home.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires improvement. This meant people's needs were not always met.

Improving care quality in response to complaints or concerns

● There was a complaints policy in place and information on how to make a complaint was displayed within the home. However, we could not see that complaints were always identified, investigated or acted on to make improvements to the service people received.

● The provider and nominated individual told us no formal complaints had been received since the previous inspection. However, prior to and during the inspection we received information that complaints and concerns had been made by staff and relatives about the service, which they had put in writing to the provider. We were unable to find any record of these complaints or concerns.

● The provider and nominated individual told us the issues raised by CQC prior to the inspection had been investigated and actions had been taken. We were told that actions taken included, meetings with staff and people, reassessments of people's needs and observations of care provided. However, the provider and nominated individual were unable to provide us with written evidence these actions had been taken. This meant we could not be assured any complaints or concerns received had been or would be investigated effectively.

● Effective management of complaints was discussed with the manager on day three of the service, who clearly demonstrated they had an extensive knowledge on how complaints and concerns should be investigated and managed. We were assured moving forward that complaints would be effectively managed.

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

● Staff were able to describe how people's personal care needs should be met and the level of support they required. For example, a staff member said, "[Name of person] needs, lots of encouragement to wash and change clothes and "[Name of person] needs prompting and support in the shower." However as highlighted in the caring section of the report staff felt they were not always able to meet people's needs as required.

● Some people's care plans identified their personal hygiene needs and some support they required to maintain aspects of their environment, this was not detailed and there did not appear to be an active strategy to support people to maintain cleanliness of their environment and good personal hygiene. This was attributed to limited staff time by the staff and respecting people's independence by staff and the provider.

● Care plans in place did not always provide staff with detailed guidance on how to meet people's specific health and emotional needs. More detail to support this can be found in the effective domain of this report.

● People confirmed they could make decisions in relation to their day to day lives. For example, what time they liked to get up or go to bed, where they spent their time in the home and if they wanted to go out. This

was observed throughout the inspection.

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

● The service employed an activities coordinator for 16 hours per week, who stated working at the service on the first day of the inspection. We discussed their role with them and they told us they would be; "Spending time out and about with people, taking people shopping and to appointments." They also confirmed for people who were unable or declined to go out they would spend time with them, talking to them or playing card or dominos.

● Staff told us they did not have the time to complete activities with people.

Meeting people's communication needs

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

● Accessible Information Standard (AIS) was discussed with the provider, nominated individual and manager on day three of the inspection. The manager was able to clearly explain how they planned to meet AIS requirements for the people living at Chesterholm Lodge.

End of life care and support

● No people living at Chesterholm Lodge were receiving end of life care at the time of our inspection.

● People's end of life wishes had been captured within their care plans. Information within people's care records detailed any funeral plans and information about whether they wished to be buried or cremated.

● Staff had not received training in end of life care but were able to describe how they would support people to be comfortable at the end of their life and that they would work closely with relevant healthcare professionals.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- There was no registered manager at the service at the time of the inspection. The last registered manager left the service on the 27 September 2019. Following their departure another manager started at the service but only stayed for one week. On day three of the inspection a new manager had started working at the service. The nominated individual told us that they had taken over the overall management of the service, following the departure of the registered manager.
- Leadership in the service was poor because the nominated individual and providers, who had taken over the overall running of the service did not understand the regulatory requirements or risk. The nominated individual and providers demonstrated a lack of knowledge and understanding of best practice guidance in key areas and this had contributed to six breaches of regulations identified at the inspection.
- Quality and safety monitoring systems were not adequate and did not identify significant risks to people or service wide failings. Some of the concerns highlighted at the inspection had been brought to the attention of the nominated individual and provider prior to the inspection by staff members however, no actions had been taken to address these issues.
- Failings that were found by inspectors had not been identified by the nominated individual or provider, this meant that people would have continued to be exposed to the risk of harm.
- Since the departure of the registered manager the management responsibilities and tasks they completed had not been undertaken. Staff had not been provided with clear guidance as to who was responsible for tasks and staff had not been given time or training on completing additional tasks required. None of the management tasks had been delegated to other staff members, yet they had taken some of these on as there was no one else to complete these, such as ordering medicines. A health professional told us, "There is a disheartened staff team, who don't know what they are doing." They added, "The staff are caring but really do need some guidance, they are not getting it."
- The nominated individual told us the last registered manager completed regular audits of the service, however were unable to provided us with evidence of these completed audits or confirm what audits were completed by the registered manager. We could not be assured that appropriate audits were completed in any areas or that actions would be taken if concerns were identified.
- The nominated individual told us they completed a monthly providers audit. On viewing the record of the last provider audit it showed this had been completed in July 2019 and covered areas including, medicines, general cleaning, staff recruitment and food. These audits were not effective and did not demonstrate that the audit completed considered actions to take to improve the quality of the service or that the views of people living at the service about these areas had been sought. This audit had not identified the concerns

we found at the inspection.
● The nominated individual had failed to ensure staff received the appropriate training they required to support them to carry out their role and meet people's needs safely.
● Although the nominated individual and provider took some actions in relation to the issues highlighted they clearly lacked insight into the severity of the issues. For example, on day one of the inspection they agreed to put in additional staffing yet had only put in one additional staff member for two and a half hours in the morning on weekdays. This was re discussed with them on day three of the inspection and it was agreed that staffing would increase, seven days per week. However, following the inspection further information was received the staffing level increase had not always been sustained.
● Staff, health and social care professionals and all but one person described the service as not being well run. A person told us, "It's gone downhill." Staff members comments included, "Well led, not at the moment", "We (staff) are not valued or supported, neither are the residents, they are just numbers on a spreadsheet. The providers are just interested in their profit margin" and "I don't think it is well run." A healthcare professional said, "The leadership has completely gone."

Continuous learning and improving care
● Effective systems were not in place to allow continuous learning and improving care. For example, accidents and incidents had not been robustly investigated to identify further risks or triggers or prevent recurrence and to help ensure people's safety.
● Appropriate and effective audits were not completed in a timely way in ensure improvements of care and promote safety. More details can be found within the safe domain.
● The provider and nominated individual told us they conducted regular observations of staff and the service, however, were unable to provide us with written evidence of this and could not demonstrate that actions had been taken as a result of these observations.
● The nominated individual did not have a formal action plan to demonstrate the plans for future development and for addressing any issues. Between day one and day two of the inspection one was completed however, reviewing this along with actions taken on day two of the inspection we could not be assured that effective actions were taken, or appropriate actions would be sustained.

The failure to operate effective systems to assess, monitor and improve the service was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● There was a duty of candour policy in place. However, when duty of candour was discussed with the provider and nominated individual we were not assured they had a good knowledge of the legal duty they should follow in the event of an incident or accident.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● It was evident throughout the inspection the service did not always promote a positive culture that was person-centred, open, inclusive and empowering, which achieves good outcomes for people. These findings are referred to throughout this report.
● The provider created some opportunities for people to provide feedback. For example, we were told quality assurance questionnaires were sent to people, families, and professionals annually. On viewing records in relation to this, it was noted that the last quality assurance questionnaires were completed in September 2018. At the time of the completed quality assurance questionnaires the management team had

monitored feedback received, which was collated, and action taken where required. However, there was no evidence that any quality assurance questionnaires which were due in September 2019 had been completed.

● We were told by the provider and nominated individual residents and relative meetings were held regularly at the service. However, when we requested the most recent meeting minutes the evidence they could provide us with were meeting for a meeting held in March 2019.

● Throughout the inspection it was evident people felt able to approach the staff and discuss any issues they had.

● Friends and family members could visit at any time.

● The previous performance rating was prominently displayed in the reception area and on the providers website.

Working in partnership with others

● Staff told us they worked in collaboration with all relevant agencies, including health and social care professionals to help ensure there was joined-up care provision.

● When staff were available they supported people to attend local community events.

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 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure people's rights are upheld within the basic principles of the Mental Capacity Act 2005.

The enforcement action we took:

We cancelled the providers registration so they can no longer provide care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure risks relating to the safety and welfare of people using the service are assessed and managed.

The enforcement action we took:

We cancelled the providers registration so they can no longer provide care.

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 failed to safeguard people from abuse and improper treatment.

The enforcement action we took:

We cancelled the providers registration so they can no longer provide care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider failed to ensure the environment was properly maintained.

The enforcement action we took:

We cancelled the providers registration so they can no longer provide care.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to operate effective systems to assess, monitor and improve the service.

The enforcement action we took:

We cancelled the providers registration so they can no longer provide care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure sufficient staff were deployed to meet people's needs at all times.

The enforcement action we took:

We cancelled the providers registration so they can no longer provide care.