Cheriton (Amersham) Ltd

Cheriton Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Cheriton Care Home is a residential care home, providing the regulated activity accommodation and personal care to up to 27 people. The service provides support to older people, including people with dementia. At the time of our inspection there was 15 people using the service.

Cheriton Care Home accommodates people in one building, over two floors.

People's experience of using this service and what we found
People told us they felt safe and were accepting of their care. Relatives were happy with their family member's care. They commented "I'm very happy and pleased with the service." Relatives felt their family members got safe care and were well looked after, with their health and care needs met. Relatives commented "I am very happy that he is safe. They(staff) do a fantastic job."

Whilst risk management had improved, not all risks had been identified and mitigated.

Staff were not suitably deployed which impacted on the care given, access to person centred activities and the cleanliness of the service.

Areas of the service had been refurbished. However, further improvements are necessary to ensure the service is safe, clean and fit for purpose.

Records had been organised and systems set up to make them accessible. However, some records were contradictory, incomplete and not suitably maintained. Auditing had commenced. Further improvements are needed to ensure the audits are picking up the issues we found, so that these are addressed in a timely manner.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People's care plans were under review and development to make them person centred. Regular person-centred activities were not established. We have made a recommendation to address this.

Safe medicine practices were promoted. People's health and nutritional needs were met. Systems were in place to safeguard people, including review and oversight of accident and incidents to mitigate the risk of reoccurrence.

Staff were suitably inducted, trained and supervised in their roles.

Systems were in place to enable people and their relatives to raise concerns. Issues raised were investigated and addressed.

The service had a new registered manager whom had made improvements to the service. They worked closely with the group compliance manager in setting up systems, auditing, and in developing the person-centred software. They had established links with relatives and were working with staff to develop and support them to improve practice to benefit people.

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 inadequate (published 20 May 2022) and there was breaches of regulations. 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 improvements had been made however, the provider remained in breach of regulations.

At our last inspection we recommended that the provider works to best practice in relation to learning from accidents and incidents, to improve their approach to developing staff and promoting good practice, to follow good practice to improve people's mealtime experiences, to seek advice from a reputable source about improving the environment for people with dementia, to be compliant with the Accessible Information Standard, to develop staff to become end of life champions and to improve their understanding of the duty of candour requirement.

At this inspection we found the provider had acted on the recommendations, made improvements and further improvements were planned.

This service has been in Special Measures since 20 May 2022. During this inspection the provider demonstrated that improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on the 4 March and 4 April 2022. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve. We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements.

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.

The overall rating for the service has changed from inadequate to requires improvement based on the findings of this inspection. We have found evidence that the provider needs to make improvements. Please see the safe, 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.

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

Enforcement and Recommendations
We have identified breaches in relation to safe care and treatment, staffing, environment, dignity and respect and good governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Cheriton Care Home

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was carried out by two inspectors over two days. An Expert by Experience was on site on day two of the inspection and another Expert by Experience carried out calls to relatives after the inspection.

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
Cheriton Care home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Cheriton Care Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there were two registered managers in post. The nominated individual is also

one of the registered managers. They are responsible for supervising the management of the service on behalf of the provider and was present during the inspection.

Notice of inspection
This inspection was unannounced.

What we did before the inspection.
The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. The last PIR on file was dated the 17 March 2022, which was during the time of the previous inspection.

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used all this information to plan our inspection.

During the inspection
We spoke with one relative and eight people who used the service about their experience of the care provided. We spoke with nine staff which included a senior carer, two care staff, the cook, deputy manager, registered manager, group compliance manager, a director and the maintenance staff member. We spoke with a visiting professional. We observed lunch 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 walked around the service and reviewed the environment. We reviewed a range of records relating to people's care which included, multiple medicine records and nine care plans. We reviewed three staff recruitment files and a variety of records relating to the management of the service, including fire, health and safety, accident/incidents, safeguarding, and audits were reviewed, and other records were requested.

Following the visit to the service we sought feedback from relatives, staff, community professionals and continued to seek clarification from the registered manager. We received written feedback from a health professional, two staff, one relative and spoke with a further three relatives.

Requires Improvement

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 inadequate. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although improvements had been made to be compliant with regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, we found all areas of risks were not identified and mitigated.

● People's care plans indicated call bells were to be checked to ensure they were in good working order. There was no detail of what that check entailed. A person told us their call bell was not working. When checked we found this to be the case. This was pointed out to the provider who immediately checked the batteries, replaced them and the call bell was back in use. However, the lack of effective checks of the call bell had the potential to put the person at risk. Another person told us their mobile call bell was taken away from them, whilst they were sat in the lounge. They told us this was because staff thought they had been over using it, which they indicated was used on behalf of other people who were in distress or in need of a staff member's assistance. The risks associated with no call bell not being available to the person had not been considered.
● For some people who smoked, the risks associated with this were identified and mitigated.However, the risks associated with smoking were not identified for all the smokers using the service.
● Risks relating to medical conditions such as diabetes had been considered for hypoglycaemics (low blood sugar) symptoms but not for hyperglycaemic symptoms. (high blood sugar). The registered manager told us a person had seizures in the past, but not occurring currently. Their care plan file made no reference to the seizures to ensure staff were aware and risks mitigated.

This is a continued breach of regulation 12, as risk management was not consistently managed.

● Other risks to people such as nutritional, choking, falls, moving and handling risks were identified, and measures put in place to mitigate them. For people who smoked the risk around the use of flammable creams had been considered and addressed, with emollients prescribed which were not flammable.
● Environmental risks, including lone working risks were identified and mitigated. Health and safety checks took place which included fire safety, window restrictors and water temperature checks. Legionella testing was completed and equipment such as the lift, fire equipment, gas, electricity and moving and handling

equipment were serviced. An up to date fire risk assessment was in place. People had personal emergency evacuation plans (PEEPs) on file and records viewed showed fire drills took place. An emergency red bag was provided to be used in the event of the home being evacuated. The contents of the bag were checked regularly to ensure information was kept up to date and that the equipment contained within it, remained in working order.

At our last inspection the provider had failed to ensure all premises and equipment was secure and properly maintained. This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although improvements had been made to be compliant with regulation 15 (Premises and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, we found areas of the service were not suitably maintained, secure and clean.

● During the inspection we identified environmental issues that needed immediate action. Some fire doors were sticking, or not closing fully with some door strip thresholds loose and lifting. A radiator cover had come loose and the flooring in a person's bedroom had split. These issues were rectified during the inspection and the provider agreed to develop their daily checks to ensure environmental and maintenance issues are identified and addressed in a timely manner.
● We found the cleaning cupboard was unlocked and the door to the lift shaft was left insecure. This was secured immediately, and notices put in place to remind staff to keep the doors locked.
● Cleaning schedules were in place; however domestic staff were not regularly provided on shift which meant the service was not clean and hygienic. The flooring in some people's bedrooms had food debris on them, sinks were not clean, and furniture was dusty. The wall in one person's bedroom was badly stained with food/ drinks splatter and looked unhygienic. The communal area floors had debris on them, the toilets and bath were stained, skirting boards were dusty and marked.

This is a continued breach of regulation 15, as the service was not properly maintained, secure and clean.

● Other improvements had been made to the environment, with further improvements planned to make the service fit for purpose. The provider had a refurbishment and replacement plan in place, which showed work that was completed, and refurbishment planned.
● New flooring had been fitted in areas throughout the ground floor of the home with soft furnishings such as curtains and armchairs replaced. The carpet in bedrooms and the landing upstairs was due to be replaced with bedrooms scheduled to be decorated and suitably refurbished prior to a person moving in.

Preventing and controlling infection
At our last inspection the provider had failed to adequately assess, prevent, detect and control the spread of infection. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although improvements had been made to be compliant with regulation 12(1), (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, we found the standard of cleanliness required further attention.

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. We found areas of the home were not suitably clean and hygienic. This is reported on under the continued breach of regulation 15 above.

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

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

Visiting in care homes
● The service was open to visitors with no current restrictions on them.

Staffing and recruitment
● Staff were not suitably deployed. The registered manager confirmed 3 staff were provided on daytime shifts, with 2 staff at night-time. The shift planners viewed showed 3 staff were provided on shift. However, when the deputy manager was rostered on shift, they rarely supported staff in providing care and support to people, which indicated 2 staff were providing care to 15 people, some who had moving, and handling needs.
● No assistance was provided to the cook. As a result, care staff were responsible for collecting meals from the kitchen and serving them. We observed at lunch time, people eating in the lounge were not consistently supervised with their meals, as the staff member was going to and from the kitchen serving meals. The other staff member observing people in the dining room with their meal, could not leave to get the puddings which resulted in a delay between the main course and pudding being served. The third staff member was administering medicines at that time.
● The 2-week rota reviewed from the 2 January to the 15 January 2023 showed 1 staff member worked 48 hours one week and 54 hours the following week. Another staff member worked 60 hours each week. This is a concern when those staff are responsible for administering medicines. Over the two-week period an agency staff member was used on one 12-hour shift, despite the rota showing all roles were not covered on shift.
● Some staff had multiple roles, for example carer/ activity co- ordinator and carer/domestic/cook. The rota viewed reflected the carer who took responsibility for facilitating activities was included in the core care hours when on shift. Whilst some activities took place, staffing did not allow for activities to be regularly provided. Domestic staff shifts were for 6 hours. On the 6 hour shift the domestic staff member was responsible for cleaning the communal areas and people's bedrooms. On the rota viewed from the 30 December 2022 to the 15 January 2023 a domestic staff member was only provided on 4 out of 17 days, for 6-hour shifts. This was a total of 24 hours domestic support over a 17-day period. The rotas showed there was no domestic staff rostered from the 30 December 2022 to the 4 January and 7 to the 11 January 2023, which was 4 and 5 days in succession where a domestic staff member was not on shift. We saw the lack of daily domestic staff impacted on the standard of cleanliness within the service.
● In response to our feedback the registered manager confirmed there was a cleaning schedule for night staff. However, limited cleaning would be able to take place at night so as not to disturb people and people's bedrooms would not be able to be cleaned. The registered manager confirmed domestic staff are responsible for the laundry and in their absence the day care staff put the washing on, and the night staff do the ironing. This further detracted from people's care.
● During the inspection a person who was sat in the lounge indicated that they would like to return to their

bedroom but was reluctant to contact a staff member for assistance, as none were visible. He commented "I will wait a bit longer, I will get someone in the end, it always varies whether they (staff) are around and if they are busy elsewhere."
● The October 2022 team meeting minutes showed staff had indicated that the issues with staffing levels was putting pressure on them. At the inspection we received mixed feedback on the staffing levels, with some staff telling us the staffing levels were currently suitable based on the number of people in the service. However, other staff told us there was a shortage of staff, despite there being less people in the service. Staff commented "We're short staffed. You can't always get a day off. You do get called in," and "We are short staffed, which makes the shift hard, when only two staff are providing care."

Staff were not suitably deployed, and roles were not covered on shift, which detracted the care staff from people's care. This is breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider confirmed two staff members had been appointed, subject to recruitment checks. One as a carer and the other to take the lead on activities. The service was advertising for a domestic staff member, cook and a team leader post was due to be advertised.

● Systems were in place to promote safe recruitment practices. Staff attended for interview and completed assessments as part of the interview process. Staff had two references on file and Disclosure and Barring Service (DBS) checks were completed. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. A photo and health questionnaire were on file and gaps in work histories explored, with right to work status established. Risks around heath conditions and any convictions on DBS's were identified and mitigated.
● The service had obtained evidence of recruitment checks and training for each agency staff member used.

Systems and processes to safeguard people from the risk of abuse
●Systems were in place to safeguard people. The provider's safeguarding policy updated in September 2022 was developed in line with Buckinghamshire multi-agency safeguarding policy.
● The training matrix provided showed all staff had completed online safeguarding training. Staff spoken with were aware of their responsibilities to report safeguarding concerns. Staff commented"If I observed anything that put a resident in danger, I would inform the senior on shift. If the resident was in immediate danger, I would inform the police," and "If I saw a resident being harmed, I would inform the manager. If not acted on I would report to CQC."
● People told us they felt safe. They commented, "Yes I feel safe and I feel that there are not too many rules and that I have some freedom." They added "I feel nice and warm and sometimes you don't realize how good your life is compared to some others," and "Yes, I definitely feel safe here, I don't know why I say that but I feel it. There have been one or two upsets with one or two people but overall, everything is settled."
● Relatives told us their family members were safe. They commented "[Family members name] is mobile and uses a zimmer frame. I'm very happy that he is safe. They (staff) do a fantastic job. He has had no falls, bruises or sores," and "My father hasn't had a fall since he has come here and he looks much better, I feel that he is safe and cared for."

Using medicines safely
● Systems were in place to promote safe medicine practices. The provider had a medicine management policy in place dated November 2022. Staff involved in medicine administration were trained and had their competencies assessed annually to administer medicines. Records were maintained of medicines ordered,

received, administered and disposed of. Stock checks of medicines took place and temperature checks were maintained of the medicine cupboard and the room medicines were stored in.
● Protocols were in place for "As required medicine" and topical administration records were in use to provide guidance on where topical creams were to be applied.
● The medicine administration records viewed, showed medicines were given as prescribed, with no gaps in administration. Medicine audits were taking place to ensure safe medicine practices were promoted.

Learning lessons when things go wrong

At our last inspection we recommended the service develops its approach to learning from accidents and incidents, to prevent incidents recurring.

At this inspection we found improvements had been made.

● Systems were in place to review accident and incidents. The provider had a policy in place which outlined their actions in response to accident and incidents. The registered manager had oversight of all accidents and incidents, which they were required to review, investigate if necessary and put measures in place to prevent reoccurrence.
● Flash meetings had been introduced, which were spontaneous meetings in response to concerns that may have arisen on the shift. This was to inform staff of expectations and required actions in response to those concerns.

Good

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 inadequate. At this inspection the rating has changed to good. This meant people's outcomes were consistently good, and people's feedback confirmed this.

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

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

At our last inspection the provider had failed to ensure people were only being deprived of their liberty by lawful authority. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

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

● People's care plans outlined if individuals had capacity or not. Where it was deemed a person did not have capacity, a mental capacity assessment and best interest record was completed in relation to aspects of the person's care, such as medicine administration, personal care, living at the service and use of sensor mats.
● Whilst improvements were made to the records relating to mental capacity assessments and best interest decisions, we saw people's care plans did not include mental capacity assessments and best interest decisions in relation to COVID-19 testing and vaccinations. In response to the draft report the registered manager confirmed MCA and DoLS guidance had been updated to reflect their responsibilities in relation to

COVID-19 testing, vaccinations and MCA's had been completed in relation to COVID -19 testing for the current outbreak.
● The service had a DoLS register in place with a record maintained of DoLS referrals made and approved. The registered manager had started the process of asking relatives for evidence of power of attorney, to ensure relevant people were consulted and involved in decisions about people's care.
● In two files viewed we saw DoLS applications were made in June and July 2022 for people whose care plan indicated they had capacity and had no mental capacity assessments on file. These were made prior to the current registered manager being in post. In response to the draft report the registered manager provided evidence of a mental capacity assessment for one person which was in place at the time of the inspection. They advised the DoLS application for the other person was made at a time when the person was deemed not to have capacity due to changes in their mental health.

At our last inspection the provider had failed to ensure people received care and treatment which met their needs and reflected their preferences. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although improvements had been made to be compliant with regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to identifying people's needs, we found certain areas in relation to care planning required further attention and these are reported on in the responsive domain.

● Systems were in place to ensure people were assessed prior to admission into the service. The registered manager was in the process of developing assessments and care plans further to make them person centred and reflective of people's needs.
● Care plans outlined people's preferences in relation to aspects of their life in line with individual's protected characteristics. Staff were trained in equality, diversity and inclusion to further promote non-discriminatory practice.

Staff support: induction, training, skills and experience

At our last inspection we recommended the service seeks advice from a reputable source to improve the approach to developing staff and promoting good practice.

At this inspection we found improvements had been made.

● Systems were in place to support staff to be inducted and trained in their role. All staff completed an in-house induction, which was completed to show the areas they had been inducted into. These were completed over a period of a week.
● The provider confirmed new staff worked shadowing shifts, alongside experienced staff for the first two weeks of employment. For staff new to care, they worked through the care certificate induction. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme. We saw evidence of the care certificate sign off for a staff member new to care.
● Staff had access to training considered mandatory by the provider such as safeguarding, moving and handling, nutrition and hydration, infection control, person centred care and fire safety. Specialist training relevant to the service was also provided which included training on mental health, diabetes and wound care management. The registered manager was trained to deliver moving and handling training. They were

keen to source other training to develop staff in champion roles such as communication, dementia, activities and death and dying.
● Staff told us they felt suitably trained and supported. The provider's supervision policy indicated staff would be provided with supervision every two months. A supervision matrix had been devised which showed when supervision and annual appraisals had taken place. It indicated when the next supervision was scheduled. This showed supervision was taking place in line with the providers policy. The registered manager confirmed they felt supported and had regular supervision with a Director. These were not recorded on the matrix and records of the supervisions were not maintained. The Director agreed to commence recording supervisions with the registered manager in line with the providers policy.

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

At the last inspection we recommended the service follows good practice to improve people's mealtime experiences, offering choices and ensuring dietary needs are met.

At this inspection we found improvements had been made.

● People were offered meal choices and drinks. Alternative food options were available if people requested it. People were provided with hot and cold drinks, with snacks available in between main meals. Some people required thickener in drinks following a speech and language therapist (SALT) assessment. Staff spoken with were aware of the thickness levels needed and how to prepare drinks for those individuals.
● Care plans outlined the support people required to promote their nutrition and hydration needs and records were maintained of meals eaten and drinks taken.
● Information on people's dietary needs were made available to the kitchen staff and this was displayed in a prominent place in the kitchen. Some people had nutritional supplements which were taken in the form of milkshakes for example (Aymes shakes). The chef told us that some foods were fortified e.g. with cream to provide more calories and prevent weight loss.
● People told us they were happy with the food provided. A person commented "The food is okay, I think I get enough to drink."
● Relatives were happy with the meals provided. A relative told us how the service had helped their family member regain weight following a hospital admission. They commented "Carers helped him get his skills back. He lost a lot of weight at the hospital and the home has got his weight back up."

Staff working with other agencies to provide consistent, effective, timely care. Supporting people to live healthier lives, access healthcare services and support.
● People had access to health professionals such as the GP, an advanced nurse practitioner, Speech and language therapist, physiotherapist, and community mental health team. The advanced nurse practitioner told us they visit weekly and liaise with the GP, who also has weekly contact with the service, via video, telephone, or visit. This enabled them to review changes in people regularly and respond to changes.
● People's care plan included a record of the outcome of health professionals review and or visit. Whilst care plans made reference to chiropody and dentist referrals and appointments, the review of care plans did not indicate when these appointments were scheduled or had taken place. This was fedback to the registered manager for them to address. The registered manager confirmed in response to our feedback that they had made the required referrals to dentists and opticians prior to the inspection and some of these had already taken place.
● A health professional commented "Several of the residents have very complex physical and mental health needs, which I feel are monitored closely and the team will raise any concerns they may have with me."
● Relatives told us they were informed of changes in their family member and the service calls the GP or

nurse if concerned.

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

At our inspection in March 2019 under the providers previous registration, we recommended the service sought advice from a reputable source about improving the environment for people with dementia. At our last inspection in March 2022, we found improvements had not been made.

At this inspection, improvements to the environment for people with dementia had been identified and commenced.

● The provider had completed "The King's Fund Audit" of the service. This is a tool used to help health and care organisations to develop a more supportive design and environment for people with dementia. The audit identified environmental improvements with an action plan in place to bring about the improvements.

● The registered manager confirmed they were looking to provide consistent signage throughout the service and was keen to develop sensory areas for people. They planned to involve the activity staff member in developing those areas around the service.
● A memory box was situated outside people's bedrooms. We found some had photos in whilst others were still waiting to be personalised. The registered manager told us they were liaising with family members to bring in photos and memorabilia to personalise memory boxes.

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 our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained 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, Respecting and promoting people's privacy, dignity and independence

At our last inspection the provider had failed to ensure people were treated with dignity and respect. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although improvements had been made to be compliant with regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, we found staff practice did not fully promote this.

● People's privacy, dignity, respect and independence was not promoted. During the inspection we observed staff did not knock on bedrooms doors prior to entering, and when they entered the bedrooms they did not always engage or acknowledge the person. When we asked a staff member if they would check with individuals (who had their bedroom door shut) if they would be happy to speak with us, the staff member walked into the person's bedroom without knocking on the door first. Some people were asleep, and another person was using the toilet.
● Throughout the inspection there was some use of terms of endearment such as "darling, dear, sweetie and "love" without it being established if individuals were happy to be addressed in that way. There was little laughter, smiling or spontaneous caring or interaction between staff and people. Most interactions were functional, efficient but brief. On more than one occasion we saw a person hold the hand of a staff member and seek some body contact when they were nearby. Although this action was not dismissed, the staff member ensured that such contact was very brief, did not engage and then swiftly moved away on to other tasks. Equally we did not hear people call a member of staff by their first names or recount situations when named, or particular staff member, performed helpful or non-routine actions for them or a peer.
● Several staff members looked serious faced whilst performing their tasks during the day. Noticeably the majority of them, when they were interacting with people seated in the lounge, continued to stand in front of the person rather than kneel or crouch down to people's eye level. Some staff stood with their arms folded or adopted tea pot style with their hands on their hips when they were speaking with people, with any physical touching or tactile movement always initiated by people.
●At mealtimes there was some engagement with people, although this was limited due to staff being involved in other tasks and people not being consistently supervised. In the lounge area staff served the meals but there was no engagement, either between people or with the staff member bringing and collecting the plates.

● During lunch we saw one person had their eye drops applied, whilst another was given their inhaler. This task was carried out during the meal, in the lounge and did not promote people's privacy and dignity.
● During the inspection we observed several staff multi tasked on occasion, for instance answering telephone calls to the service and dealing with those enquiries on a mobile phone, in communal areas whilst also delivering and clearing lunch plates to and from people.
● We observed people did not receive much verbal or aural stimulation. Whilst they were compliant with this, they did not voice their opinions and request, or expect, more than they currently received. Several people noted that they had enjoyed the experience of chatting with us as they said they did not get similar opportunities very often. A person commented "I must say I have seen our chat as marvellous and I have thoroughly enjoyed it." Another person told us they were lonely and isolated. They commented "Night times are the worst, you can't see or speak to anyone for hours and it would be nice if someone would come and see me and chat. You (the EXE) are the first person that I have spoken to like this for a long time, and I really appreciate it. Loneliness is horrible. I am out of sight and out of mind."

This is a continued breach of regulation 10 as people's privacy, dignity and independence was not promoted and respected.

● The registered manager had commenced dining room audits and addressing issues with staff.
In team meetings staff were reminded that the service was the person's home and the need for staff to respect that.
● Relatives were positive about the staff, with one relative telling us how they had observed a staff member talking to their family member on a recent visit and commented "He was very comfortable with her." Relatives commented "They (staff) are caring and careful" and family member is happy with the staff," and "The staff are very nice, helpful and welcoming to us," "The staff are very kind and we have not had any issues. They don't speak abruptly and don't rush people. They are very compassionate. The staff are friendly with him and call him by his first name. They know a lot about him."
● A person commented "I get on well with most of the staff, there is one lady who is very good, she is the one who will listen."

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

● People in the dining room were supported to make decisions and choices in aspects of their daily life's such as meals and drinks. People in the lounge were not shown meal choices available to them.

Requires Improvement

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 remained requires improvement. This meant people's needs were not always met.

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

At our last inspection the provider had failed to ensure people received care and treatment which met their needs and reflected their preferences. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although improvements had been made to be compliant with regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to identifying people's needs, we found further improvements were required.

● Person centred care plans were under development. People had care plans in place in relation to capacity; communication, hearing and sight; mobility; nutrition, hygiene, skin integrity; specialist needs and end of life care. Those were kept under review.
● Care plans were generally detailed in identification of people's needs. However, they lacked details on how the care was to be provided. For example; care plans on personal care did not outline staff's approach if a person was regularly refusing personal care. A person's care plan referred to behaviours that challenged. However, there was no detail on how that presented or was to be managed.

It is recommended the provider works to best practice to further improve care plans, involve people in them to make them person centred.

● People had not signed care plans to show their involvement in them. The registered manager was keen to involve people and/ or their relative in care plans reviews and the minutes of a relative meeting held in September 2022 showed this was discussed.
● A health professional involved with the service commented "All staff are responsive to suggestions and requests to make adjustments to any issues raised. Care plans are now being regularly reviewed and I often receive positive feedback from the residents about the care that they receive."
● Relatives told us the service was responsive to changes in their family member. A relative told us their family member was moved downstairs due to changes in their needs and abilities. Relatives felt their family members were well presented, clean and cared for.

End of life care and support

At the last inspection we recommended the home develops staff to become end of life champions to make

links with hospices and research training so that this learning can be put into practice as people's health deteriorates.

At this inspection improvements were underway.

● People's end of life preferences were established with "Do not attempt cardiopulmonary resuscitation (DNACPR)", in place. People's care plans titled "Hopes and concerns" outlined people's end of life choices. Some people choose not to outline their end of life wishes and this was recorded.
● End of life training was being sought but not yet provided. The registered manager was keen to develop champion roles in a range of topics, including end of life, once staff were suitably trained for the role.

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
● During the inspection we saw an exercise class and music and games session took place, which were facilitated by external contractors. The physiotherapist which led the exercise class also provided one to one exercise for people cared for in bed.
● An activity programme was in place which showed the activities scheduled, which included activities such as listening to music, board games, quizzes, movie time and reminiscing sessions. The shift planner and activity programme showed that bingo was scheduled on day two of the inspection. This did not take place. We saw that staff responsible for activities were included on shift, therefore time was not allocated to ensure the planned activities took place.
● The registered manager had identified people's wishes and interests. They confirmed they were aware activities was an area for improvement. They had recently recruited a staff member to lead on activities, with the aim being that they would look at providing opportunities for people to fulfil their wishes and pursue their interests and hobbies.
● In the afternoon of day two of the inspection, music was put on in the background rather than as a shared activity. A person commented, "I know the words but have no one to reminisce with," and "Watching television is my only activity. The TV is put on for me in the morning, but I have no idea what is going to be on. I like the old films on TV. I love them but I haven't seen one for ages. I like Pinewood films, but I never know if they are on."

It is recommended the provider works to best practice in the development of person-centred activities.

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.

At our inspection in March 2019 under the provider's previous registration, we recommended the further work was undertaken to ensure the home fully complied with the Accessible Information Standard. At our last inspection In March 2022, we found improvements had not been made.

At this inspection improvements were underway.

● The provider had guidance available on the accessible standards. This was displayed on a notice board

and available to people. Some information had been developed in a user-friendly format, such as the service user guide and activity programme, with bright colours used to highlight people's wishes and aspirations in relation to activities or interests they had. Further improvements were planned as part of the development of activities and the environment.

● People's care plans identified their communication needs and the support required.

Improving care quality in response to complaints or concerns

● Systems were in place to deal with complaints. The provider had a complaints policy which, indicated complaints would be investigated and a response provided within 28 days. It outlined who the complaint could be escalated too, including the Local Government and Social Care Ombudsman's contact details.

● A system was set up to log complaints. Two were recorded since the previous inspection which showed the nature of the complaint, action and outcome. Compliments were logged which showed relatives thanks to staff for the care provided.

Requires Improvement

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 inadequate. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

At our last inspection the provider had failed to ensure systems or processes were in place to assess, monitor and improve the quality and safety of the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although improvements had been made to some aspects of record management and auditing to mitigate risks and meet regulatory requirements be compliant with regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, we found some records were not accurate and complete.

● People's records were contradictory. A person's care plan indicated a DNACPR was not in place. However, we saw a DNACPR was put in place on a recent admission to hospital, which was before the date of the review of the care plan. Another person had a DNACPR in place however, their care plan indicated they are for hospitalisation and active treatment, which contradicted the DNACPR. People's files were contradictory as to the frequency of podiatrist and dental appointments.
● People's records were not accurately completed to indicate baths and showers were encouraged, offered or refused at the frequency determined in their plan of care. This meant people were not having regular baths/showers. A sentence in a person's care plans referred to another person's name. People's records viewed were not audited for accuracy and clarity, which meant there was grammar errors throughout.
● Some other records relating to the running of the service were not suitably maintained and accurate. Staff induction records were not routinely signed off to indicate if the staff member was suitably inducted. The initial rota requested and provided, and the revised rota provided in response to our initial queries was not an accurate reflection of the staff on duty. Where agency staff was provided, this was not recorded and when staff changed their role or shift the rota did not reflect this.
● The rota reflected the hours worked as opposed to the shift worked, which had the potential for there to be gaps in the rota. During the inspection we saw a staff member came on duty at 1.00pm. The rota and shift planner did not reflect this or if they would finish the shift at 7.00pm or 8.00pm.
● The service had a shift planner in use. However, the shift planner was not person centred and did not outline which staff were supporting individuals. It read more like a task list as opposed to ensuring people got the care they required. When the deputy manager was included on shift, they were rarely recorded as assisting on the shift. It was not recorded who was responsible for administering medicines, serving meals,

supervising meals or assisting people in their bedrooms with meals. Staff breaks were not consistently recorded either. This had the potential for people's care needs, not to be met.
● Fire check records showed gaps in recording with no schedule in place to identify the frequency of in-house checks, to ensure they were consistently carried out. The water temperature records showed staff had recorded the water temperature in one bedroom was consistently higher than the recommended safe temperature, with no indication any action was taken. This bedroom was not in use at the time and people were not put at harm. However, staff were not clear of their responsibilities and action required in respect of tasks delegated to them.
● Whilst auditing had improved and was taking place, some audits had not identified the issues we found or some aspects of the running the service were not audited. Environmental audits took place, including a two weekly manager's walk around and an internal contractor had carried out a health and safety audit. However, we found the issues we found with the environment were not identified by the provider's audits, to enable them to be addressed in a timely manner.
● The staff rota was not audited, which meant it was not suitably maintained, accurate and resulted in occasions where key personnel such as domestic staff were not on duty. This impacted on the standard of cleanliness within the service.

This is a continued breach of regulation 17. Records were not suitably maintained, and aspects of practice were not audited.

● Other audits of practice had been put in place. Monthly provider's visits were carried out quarterly, with actions plans from the providers audit reviewed monthly. We saw those audits had identified shortfalls in records, medicines, supervisions, training and these were followed up at subsequent visits. Alongside, these in-house audits took place which included infection control, medicine audits, dining room audits, weights, wound care and dependency audits. The electronic auditing system in use allowed the provider to have oversight of aspects of care, such as accident, incidents, complaints, safeguarding, staff supervision and training.
● The registered manager had commenced two weekly walk arounds with records maintained of the findings. An action plan was in place to address findings.
● Improvements were made to other records such as accident, incidents, safeguarding, complaints and health and safety checks and filing systems were set up and organised, which meant the information was accessible.

At our last inspection the provider had not notified us of all events it was required to. This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18 (Registration Regulations).

● The provider is required to inform us of incidents such as an injury to a person. The registered manager was aware of their responsibilities to make notifications to us, in respect of events in the service.
● Notifications had been received in respect of deaths and deprivations of liberty safeguards approvals.

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

At our inspection in March 2019 under the providers previous registration, we recommended the registered manager followed good practice towards fully demonstrating the duty of candour requirement. At our last

inspection In March 2022 we found improvements had not been made and a further recommendation was made.

At this inspection we found enough improvements had been made.

● The provider had a duty of candour policy in place and a standard template letter was included, which was developed in line with regulation 20.
● Whilst no duty of candour incidents had occurred in the time under review, the registered manager was aware of their responsibilities in respect of a duty of candour incident.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Since the previous inspection a new registered manager had been appointed and commenced working at the service in September 2022. They had introduced changes and brought about improvements to the service. They were keen to make the service homely, person centred, improve access to activities, develop the staff team in their roles and promote open communication. We saw the registered manager worked on shift with staff to cover shortfalls in the rota, which staff found supportive. A staff member commented "We all know we can go to them at any point if we are struggling or needing support."
● Staff were generally positive about the registered manager and the changes they had brought to the service. Staff commented, "I like this new manager. She is calm, nice, friendly and experienced. This has resulted in staff being relaxed and your motivation builds up," and" The manager has brought peace, cheer, joy and they are helping staff to be motivated."
● Staff felt the registered manager and provider was trying to improve the service. They commented "I think they are trying. Some of the problems are fundamental. Everybody here works hard. You get very little recognition for it. It hurts morale." This was fedback to the provider to be aware of and explore with staff.
● Some people were aware who the registered manager was, whilst others indicated they did not know them. People commented "The leader comes around, she is very nice, but she doesn't stay with me here very long."
● Relatives told us the registered manager was accessible and approachable to them. They commented "I have spoken to the new manager and she is excellent. She is caring and knows what is going on. The place is running well enough," "The manager and deputy manager are very nice and usually answer the phone. The home seems to run smoothly," and "The new manager is very nice and efficient... I think the admin has been sorted out. The management seems brilliant and much more efficiently done. It's getting things done."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Systems were in place to get feedback on the service. A resident survey was completed in May 2022 and surveys were sent to family members, which were not yet returned. Two family meetings were scheduled to introduce the new registered manager to relatives. These showed low attendance and the registered manager was considering how these could be made more accessible to relatives.
● Monthly team meetings were taking place which showed staff were reminded of expectations of role, as well as updating them on changes within the service. We saw conflict within the team was addressed.
● Staff felt teamwork and communication was improving. A staff member commented "Staff are working together, sharing the tasks and things are run smoother."
● A resident of the day system was in use and the team meeting minutes showed staff were reminded of their responsibilities in relation to it. People had a key worker, which was a named staff member to promote communication with the person, their relative and the service.
● Relatives told us they have regular calls with the service and get updated by email and sent photographs

of any events or any formal information. A relative commented "Communication has improved over the last year."

Continuous learning and improving care, Working in partnership with others

● The registered manager was keen to develop and train staff in champion roles such as infection control, communication, end of life and dignity champions. They were looking to access external training to provide staff with the skills.

● The service worked closely with health professionals. A health professional involved with the service commented "I feel standards in the home have improved significantly in the last 3-4 months, as both the new Manager and deputy Manager have strived to address all aspects of the resident's care. I feel that the working relationships have improved in Cheriton and their staff appear to feel more supported with the change in the management team."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Staff practice did not promote people's privacy and dignity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment All areas of risk were not identified and mitigated to promote safe care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The service was not suitably secure and clean.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Good governance was not suitably established to ensure records were suitably maintained and accurate.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not suitably deployed, and roles were not covered on shift, which detracted the care staff from people's care.