Anchor Hanover Group

Linwood

Inspection report

9 Mercer Close
Thames Ditton
Surrey
KT7 0BS

Tel: 02083356800
Website: www.anchor.org.uk

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
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
Linwood is a residential care home for up to 67 in one adapted building across three floors. Linwood provides care to older people who may have a physical disability or may be living with dementia. On the day of the inspection there were 44 people living at the service.

People's experience of using this service and what we found
People's medicines and risks associated with their care were not always managed in a safe way.

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

Care was not always provided that met people's individual and most current needs. This included the lack of accurate care plans, the lack of activities for people and the environment not set up to meet the needs of people living with dementia. Staff were not always familiar with people's needs and supervisions were not taking place with staff to assess their performance. Although there were sufficient numbers of staff, they were not always deployed effectively to ensure good delivery of care. We have made a recommendation around this.

We observed examples of people not always being treated with respect and dignity. Although people and their families did feedback there were staff that were kind and caring. People and relatives fed back they were not happy with the quality of the meals although there were steps being taken to address this. People choices around care delivery and meals choices were not always considered. We have made a recommendation around this.

There was not always a record of the investigation into complaints that had been made. We have made a recommendation around this. There were other complaints that had been addressed to the person and relatives' satisfaction. There was a lack of communication between staff at the service which was impacting on the delivery of care. The provider had not ensured systems and processes were established and operated effectively. Audits were not always identifying areas that required improvement. People fed back they liked the manager who had recently joined and could see they were making positive changes at the service.

Rating at last inspection and update
The last full rating for this service was requires improvement (published 8 October 2019). We undertook a focused inspection more recently however we only looked at Safe and Well Led. Both of these domains were rated good (published 13 July 2021)

Why we inspected
The inspection was prompted in part due to concerns received about the management of medicines,

staffing and incidents of accidents and incidents. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well led sections of this full report. You can see what action we have asked the provider to take at the end of this full report. After the inspection the provider took action to mitigate risks to people.

Enforcement and Recommendations
We have identified breaches in relation to the safe management of medicines and risks to people's care, lack of detailed care planning and activities and the requirements of the mental capacity act. We found breaches in relation to people not always being treated with dignity and respect, staff not being supervised in their role and lack of robust 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.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always 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?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Linwood

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
Our inspection was completed by 3 inspectors.

Service and service type
Linwood 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. Linwood 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 was not a registered manager in post. However, a new manager had started at the service who was applying to be registered. They and the providers regional support team were at the inspection.

Notice of inspection

This inspection was unannounced.

What we did before the 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. 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. We used all this information to plan our inspection.

During the inspection
We spoke with 9 people who used the service about their experience of the care provided. We also spoke with 3 relatives and 2 health care professionals. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records including 6 people's care plans, daily care notes, medication records, safeguarding records and incidents. We reviewed a variety of records relating to the management of the service including supervisions, training and recruitment files. We spoke with 9 members of staff including the manager, regional manager and care staff.

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 good. 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.

Using medicines safely

- Prior to the inspection we received concerns from the provider in relation to the safe management of medicines they had identified. We found the management of medicine was not always undertaken in a safe way which put people at risk.
- We observed a member of staff administering a person's medicine. They left the medicine with the person as they did not want to take it at that moment. The member of staff told us this was a common practice to leave the medicine for the person. They said they would rely on the person telling them they had taken the medicine. We fed this back to the manager who told us this practice was unsafe and staff should be witnessing the person taking their medicine.
- We found 8 gaps on January 2023 medicine review records (MAR) where staff had not signed to say whether the person had received their medicine. This meant the next carer to give medicines would not know if a gap meant a medicine was not given, or the previous carer gave the medicine but forgot to complete the MAR chart. We did however check the counts of medicines which indicated the person had received their medicines.
- On one MAR the person had refused their medicines for the previous four days. There was no information to show how staff were responding to this. Staff told us they could not force the person to take the medicine and had made an appointment to speak with the GP the following day. Action should have been taken sooner in relation to the person refusing the medicine as this could have had impact on their health.
- There was medicine that had not been dated on opening that had a limited 'shelf life' including eye drops and creams. There was a risk people would receive medicine that was out of date and therefore impact upon its efficiency and safety.
- There was a lack of protocols for 'as and when' medicines in the MAR which meant that staff did not clear guidance on what the medication was being used for, what symptoms to look out for and when to offer this to the person. After the inspection the provider told us the protocols were kept separately but have now been placed with the medicine record.
- There were regular agency staff that administered medicines to people. However, there was no formal assessment of agency staff competency, to administer medicine to ensure this was being done safely and in line with the provider's policies. After the inspection the provider gave assurance the competency assessments would be undertaken.
- At the front of each MAR folder there was a list of signatures of staff who had signed to say they were trained and authorised to administer medicines. The regional support manager told us the agency staff who administered medicines were not required to sign this. They were unable to confirm why this was not a requirement.

The failure to always manage people's medicine in a safe way was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● People's medicines were recorded in all the MARs and were easy to read. The MAR chart had a picture of the person and details of allergies, and other appropriate information. There was a dated photograph to ensure staff knew who to administer the medicine to. The manager told us they were working on the concerns around medicines and, "I am having daily meetings with the staff and mistakes are reducing."

Assessing risk, safety monitoring and management

● Risks associated with people's care was not always managed in a safe way. According to their care plan one person was at high risk of malnutrition. The tool used to determine the level of risk had not been completed since October 2022. The person's weights on a separate record differed to the weights recorded on the tool. The manager told us they were not confident the weights recorded were accurate. The person's nutrition care plan stated the person required regular snacks in between meals. However, a member of staff confirmed to us the person was not offered any snacks between breakfast and lunch. After the inspection the provider confirmed they had weighed the person after the inspection and the person had lost a further 3 kilograms.

● Another person's care plan recorded advice from the community dietetics was for the person to have daily homemade milkshakes and a high protein diet. A member of staff told us, "The chef knows he should have a high protein diet, but when the food comes up it is the same as everyone else." We noted the person had the same meal as other people at the service and was not offered a milkshake on the day of the inspection.

● Some people were at risk of skin breakdown as steps to mitigate to the risks were not always followed by staff. According to one person's care plan they were at high risk of developing pressure sores. Their last recorded weight was 64 kilograms (kg) yet their pressure mattress was set at 100 kg which would reduce the effectiveness.

● One person's mobility had reduced and according to their care plan they required a hoist. When we spoke with a member of staff, they told us, "I don't think [person] has been using the hoist because she hasn't been assessed." However other staff we spoke with told us they had used the hoist with the person and were not aware they had not been assessed. This lack of communication and understanding presented a risk to the person as staff were not aware of the support the person now required.

● People at risk of falls were not always appropriately supported to reduce the risks. One person who had frequent falls was required to have a crash mat in the room and to have a sensor alarm in place. According to the care notes staff had recorded the sensor alarm had not been working for three days prior to the inspection. This put the person at risk as staff may not be aware if the person had fallen. The manager told us they would ensure the alarm was fixed.

● We were not assured that the provider was always promoting safety through the layout and hygiene practices of the premises. One room smelled strongly of urine and another room had an empty urine bottle in the bathroom which had not been cleaned appropriately which also smelled strongly. The provider addressed this immediately. A person's chair and pressure cushion were dirty and there was a malodour in their bedroom. The arm of the person's wheelchair was degraded which posed an infection control risk.

The failure to always manage risks associated with people's care in a safe way was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● After the inspection the provider contacted us about the actions they had taken. All people's pressure mattresses had been checked to ensure they were set correctly, and daily checks implemented.

● There were elements of the assessment of risk that were undertaken in a safe way. Where people required a modified diet to reduce the risk of choking this was provided.

● Where people were at risk of falling out bed, crash mats were placed by their beds and the beds lowered. There were people who had consented to sensor mats in their room so staff could be alerted if they were walking around. One person told us, "This mat has a wire, if I put my foot it will let the staff know. They are frightened I will fall as I keep having falls." They told us this reassured them having the mat in place.

Staffing and recruitment
● Although there were appropriate numbers of staff, they did not ensure they regularly visited people in their rooms who were at risk of isolation. Comments from people cared for in their rooms included, "They [staff] don't come to see me, only once or twice. I am a bit lonely" and "I do miss people, that's a bit of a problem. Staff don't have a chance to chat."
● We observed on all floors staff frequently congregated in the lounge area where there were some people were sitting. However, the majority of people were being cared for in their rooms. Staff were not proactive in spending time with people in their rooms and engaging with them.
● People and relatives fed back that the high use of agency staff meant that continuity of care was at times compromised. However, they also fed back there were sufficient numbers of staff. Comments included,", "I think there are enough of them. I don't have to wait" and "There is always someone around, but if not, you have your call bell to call them."
● Staff fed back the deployment of staff was not always effective and felt pressured. Comments included, "The middle floor is challenging; it's hard work and the shifts are long. We don't take a break; we don't have time. The staffing is better now though" and "Sometimes it's fine but other times there is a lot of pressure. When it's lunchtime and personal care times it can be pressured."

We recommend the provider ensures staff are effectively deployed around the service.

Learning lessons when things go wrong
● Aside from the concern with one sensor alarm, where other accidents and incidents occurred, staff responded appropriately to reduce further risks. This included where people had behaviours that challenged or where people had fallen.
● All accidents and incidents were reviewed by the manager and provider to look for trends. Actions were then taken to reduce the risk of incidents occurring. For example, where one person had fallen, a sensor beam had been put into place, so staff were alerted when they left their room.
● The manager told us, "The falls have reduced. All the residents at high risk of falls have been reduced." We saw this from the incident reports. The manager told us this was as a result of increasing staff levels, reviewing people's medicines and referring people to appropriate health care professionals.

Systems and processes to safeguard people from the risk of abuse
● People told us they felt safe with staff with comments including, "They are not bad at all" and "They talk and explain things to me."
● Staff understood safeguarding adults' procedures and what to do if they suspected any type of abuse. One member of staff said, "If the resident was at risk, I would remove them [from the risk] and report it." Another told us, "I would feel comfortable reporting it myself if I felt immediate action was needed. We want our residents to be safe."
● The manager highlighted safeguarding key issues and facilitated conversations with staff to raise awareness of safeguarding best practice. We saw that where there were any concerns raised, the manager would refer this to the Local Authority and undertake a full investigation.
● Staff were aware of the different types of abuse and who to report their concerns to. There was a safeguarding policy in place and staff had received training in safeguarding people.

Preventing and controlling infection

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was 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.

Visiting in care homes

The care homes approach for visitors was in line with current government guidance. People and their relatives were positive about their experience of visiting and being able to see their families throughout the pandemic.

Requires Improvement

Is the service effective?

Our findings

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

At our inspection in November 2019 we rated this key question requires improvement. This was due to improvements needing to be embedded from concerns we had identified at previous inspections. At this inspection the rating has remained requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

● People and relatives told us that due to the high use of agency staff there was a lack of consistency of care. Comments included, "Staff not well trained, they can look a bit vague. Having new staff and not knowing who they are", "A lot have left and agency don't know us because we don't see them all the time" and "The problem with agency staff is there are no carers Dad can relate to. Team leaders and carers can work on different floors during different shifts, so there is no continuity." A member of staff said, "Irregular faces and people [staff] do things differently. It doesn't flow and stalls at times."

● Staff had not received an appropriate induction relating to people's needs. Staff told us when they first started working at the service, they did not read people's care plans. This meant they were relying on other staff to provide this information

● Although staff had received the service mandatory training, this was not always effective in ensuring appropriate care was delivered. For example, we found shortfalls around the assessments of people's capacity, the management of risks to people and the safe management of medicines. A member of staff told us, "We would benefit from more in-house training."

● Whilst staff ensured people were referred to health care professional when needed, they were not always following the guidance provided. One person's nutritional care plan had recent guidance from the Speech and Language Therapist (SaLT) which requested staff record a coughing diary for up to two weeks. Staff were not aware of the location of the diary or whether it was being completed.

● After the inspection the provider confirmed the diary was not being completed by staff. They said they had referred the person back to SaLT.

● We noted that one person required to have their blood sugar levels checked daily and for this to be recorded. However, the records were last completed in August 2022. The relative told us, "My concern is staff are not trained to check blood sugar levels." We confirmed from training records that staff had not received training in relation to this. This meant, if the person's blood levels were not safe staff may not be aware.

● Care staff had not always received appropriate support that promoted their professional development and assessed their competencies. The regional support manager told us, "We use a high use of agency, around 75 to 80%. The same staff are used with agency." However, they also told us they did not undertake supervisions with any of the agency staff. They said, "We've never thought about doing supervisions." They told us they would look into starting these.

● According to the supervision records provided by the manager, of the 59 substantive staff, 31 had not had a one to one supervision with their manager for more than 12 months. Comments from staff included, "I have never had a supervision", "I have had one supervision in a year" and "I haven't had it for a long time."

There was a lack of appropriate staff training, knowledge and competency This is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

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

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

● Where decisions were being made for people there was not always evidence that their capacity had been assessed appropriately. One person was deemed to lack capacity in relation to living at the service. It was recorded they had the COVID booster vaccination however there was no evidence of a capacity assessment or evidence of a best interest meeting in relation to this or any other vaccinations.
● Where capacity assessments were completed these were not always recorded appropriately. For example, in one person's care plan there was a capacity assessment in relation to a sensor mat. Where the assessment required evidence to support the judgement of the person lacking capacity this was left blank. Therefore, we were not able to determine how the member of staff concluded the person lacked capacity.
● One person's care plan stated they lacked capacity in relation to having the COVID vaccine. However, the assessment was not completed fully. There was a record in the person's care plan around an activity the person liked to participate in which staff recorded may not be healthy for the person. It was recorded the person promised not to partake in this activity, 'too much'. No capacity assessment was undertaken with the person to determine whether they understood the risks to them.
● Another person had a sensor alarm in place so that staff were alerted if they had fallen. There was no capacity assessment or best interest recorded in relation to this restriction. Staff were also making decisions about which visitors could support the person to go out without assessing the person's capacity to make this decision for themselves. Where a best interest meeting was held in relation to the person living at the service, the person's family were not recorded as to being involved in the discussion.
● Where DoLs applications had been submitted to the local authority, we found it was not always appropriate to do so. In one DoLS application in relation to the locked front door, staff had noted the person had capacity, but this may change. In this instance there would be no requirement to submit a DoLS as this is only required where the person lacked capacity over the particular restriction.

Staff has not appropriately followed requirements of the MCA and consent to care. This is a breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Adapting service, design, decoration to meet people's needs; Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The manager told us all the people living on the middle floor were living with dementia. The design of the

environment was not set up to meet their needs. There was no clear signage to help orientate people to the communal areas or bathrooms. There was a sensory room available although we did not see this being used.
● People living with dementia may need help with finding and recognising their bedroom. However, there were not always memory boxes or memorable references for people outside their rooms other than a name plate on the doors written in small writing.
● Information about people's needs had not been always been fully assessed before they moved in to ensure that they knew the service could meet their needs. There were not always pre-admission assessments in the care plans. Of those we reviewed they were not always completed fully. In one, we noted just one word responses were written in responses to the questions including one person who was known to have distressing behaviours.

The provider had not ensured an assessment of the needs and preferences for care and treatment of people was undertaken appropriately and the environment had not been set up to ensure it met people's needs. This is a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were en-suite bathrooms for people and adapted bathrooms that suited people's individual needs. Each floor had small several lounge areas for people to use which we saw being used.
● The corridors were wide which allowed for people who used wheelchairs to access independently where appropriate. There were sheltered areas in the garden.

Supporting people to eat and drink enough to maintain a balanced diet
● There were varying responses from people about the quality of food they received. Comments included, "It's not too bad but sometimes it's not cooked properly", "If there were more options it would be nice", "As far as I'm am concerned its ok", "The food is a bit of an issue. It's not cooked very well or presented nicely. The manager is trying to sort it out" and "It's absolutely disgusting. It's all messed up."
● Relative also fed back on the quality of meals provided to their loved ones. Comments included, "The food is cold, and they run out of elements of the meal" and "It's cold usually when it comes and very seldom is it covered when they bring it from the kitchen to her room. It's adequate but she's not well enough at the moment."
● The manager told us there had recent meetings with people about the menu and we confirmed that from minutes of a meeting. People fed back what they would like to see more of on the menu. One person told us as a result, "The food is improving. The last few days it's not been too bad. I think the new manager is helping with that."
● We observed the meal experience was varied on each floor. There were people who were offered a visual choice of meals yet on the ground floor people were verbally offered choices. There were people who struggled to understand what the verbalised options were. People on a modified diet were not given options as their meal was already plated up by the kitchen staff. We also noted that people in their rooms had to wait until all people in the dining room had been served first. On the ground floor people waited an additional 30 minutes for their meals.
● Where people required support to eat this was provided by staff. Staff went at a good pace for people and no one was rushed. We observed people ate well and seemed to enjoy their meal.
● We observed people were offered drinks throughout the inspection. However, people were not offered snacks in between meals.

We recommend the provider ensures people are able to make choices about their meal choices and people always have access to nutritional meals.

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

● We saw that people had access to appropriate health care professionals. People were supported referred to SaLT, physiotherapist, GP, dentist and hospital appointments. A relative told us, "You get the district nurses in, and she is on Parkinson meds which they manage well." A health care professional told us, "They are quick to respond to patients."

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 good. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

● Staff were not always considerate of people's needs and wishes. One person, who was in bed, fed back to us they were cold in their room. They said the room had been cold since at least the day before and we noted the room was cold. We raised this with staff who identified that the person's radiator had been turned off. However, staff had not looked in to why the person's room was cold until we raised this. Instead they had just covered them with an extra blanket on their bed.

● We noted from the same person's care plan they were able to use their call bell. However, we observed staff had not ensured the person's call bell was within reach. We observed the person having to call out to staff on two occasions to get their attention. Although staff responded it would have caused the person less anxiety if they had access to their call bell.

● People were not always treated with dignity and compassion. We observed staff supporting one person to transfer from a wheelchair using a hoist. The person was very sleepy and there was very minimal communication from staff despite the person showing signs of anxiety saying, "Help me, help me." The person's foot brushed the bottom of hoist which alarmed the person, but staff did not acknowledge this.

● On another occasion a person was sat at the dining area in their wheelchair. Two staff approached the person with one saying to them, "We need to check something with you." A member of staff put gloves on and placed their hand down the person's lower clothing to check their continence aid. Although no other people had witnessed this, we raised concerns with the staff this was undignified for the person.

● One person had their loved one visiting them and whilst we were speaking to the visitor, a member of staff interrupted our conversation. They abruptly told the visitor they were blocking the way. We observed there was plenty of space for people and staff to pass down the adjacent corridor if they had needed to get by. The visitor did move away from the person they were there to see but this then caused anxiety for the person when trying to walk over to them and could not see them.

As people were not always treated with dignity and respect this a breach of regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Despite these concerns people and relatives did feedback on the caring nature of other staff. Comments included, "Staff are kind and caring. They have patience with me", "The staff are very kind" and "Staff are lovely."

● We saw examples of staff treating people in kind and caring way. One person was seen to be slightly coughing. A member of staff went straight over the person with a tissue. The person responded, "Thank you

darling."

● We saw other staff offer reassurance and comfort to people where they were anxious. For example, one person became distressed. A member of staff attempted various ways to try and give the person assurance. They settled on playing instruments along with the music which the person and others enjoyed. The same person was later seen sitting with a member of staff who was gently stroking their back and the person was smiling.

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

● Peoples wishes and views were not always considered by staff. One person told us they did not like large meals. They said, "They give you such big portions. The food wasted here is diabolical." We heard the person ask staff for a small portion for her meal however staff still plated up a large meal. The person said to the member of staff, "I only wanted a tiny bit."

● On the middle floor, according to their care plan, one person's preference was to have a female carer supporting them with personal care. Despite this we noted from the person's care notes between the 1 January and the 10 January it was recorded on seven occasions the person received care from a male member of staff. The relative told us, "What really upsets me is the young lads help her. She would have hated it."

● On the top floor we observed people being supported with the independence. People were seen coming into the kitchen to use the microwave independently or make their own drinks. One person assisted staff to hand out meals to people.

● People were able to lock their rooms when they left their room. One person told us this was important to them. They said, "Its smashing, I can lock my door."

Requires Improvement

Is the service responsive?

Our findings

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

At our inspection in November 2019 we rated this key question requires improvement. This was due to improvements needing to be embedded from concerns we had identified at previous inspections. At this inspection the rating has remained requires improvement. This meant people's needs were not always met.

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

- People fed back there was not enough to keep them occupied at the service. Comments included, "There are less activities than we used to have. I do join in on things going on that I fancy, but nothing much going on today" and, "We have been taken out but that's not happening much. Would like to go out more." A relative told us, "There used to be more to occupy her."
- During the inspection there was a lack of meaningful activities and stimulation for people. Whilst there were some people that had some individual meaningful interactions with staff including nail painting, reading poetry and playing boards games, this was not typical for all floors. On the ground floor, interactions were limited to two people in the lounge. There were two other people in the lounge, but staff were not interacting with them and we saw them dozing on and off. The television was showing cartoons all the morning, but no one was watching this.
- The majority of people on the ground floor that either chose to stay in their room or were being cared for in bed. There were no room activities planned for them. One person in their room told us, "Not enough to do, I sit in the chair all day. I am bored to tears."
- On the middle floor, although there was a music activity in the afternoon which people enjoyed, there was little engagement or activity during the rest of the day. A member of staff told us, "It can be difficult due to dementia, but we can have a dance with a couple of them. The others seem to sleep a lot. It may be the weather or something." The member of staff had not considered people may be sleeping as there was nothing to stimulate them. A relative told us, "She's been sat in her room most of the time since she's been here just watching TV."
- The regional support manager told us they had a 'wellness lead' who coordinated activities for care staff to undertake with people. However, staff we spoke told us they did not have time to spend time with people with activities. One said, "Staff just don't have time. We need someone dedicated in engaging with people, especially on the middle floor."
- Each person had a 'hobbies and interests' page in their care plan detailing what people were interested in. When we checked the activity diaries for people in January 2023 the diaries had not been completed. A member of staff told us, "No one writes what has been a success and so there's no feedback to let you know what people like."
- The activity timetable displayed on the notice board for the week was sparse. On the day of the inspection the timetable stated it singing. We did not see this activity taking place on the ground and top floor. A member of staff said, "There's not enough [for people to do]. I've said it in meetings. We need things accessible. We haven't got the right equipment such as Bingo. I'm always having to search for things to do rather than it being just there."

There was a lack of engagement and activities to meet people's individual and most current needs. This is a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

● There was not always sufficient guidance in the care plans around the specific needs of people. One person's care plan stated they had, 'Unpredictable behaviour.' The information for staff described the person's behaviours but not what the triggers were. The only guidance given was for staff to move away and offer medication. This meant that there was a risk that staff would not deliver the most appropriate care.

● There was conflicting information in people's care plans around their needs. The care plan stated the person's preference was to sit in the lounge area and dining room to socialise with people. However, their care plan also stated the person was permanently cared for in bed. This would cause confusion for staff who did not know the person's wishes.

● A person's fire evacuation plan stated the person required a full body hoist as they were no longer able to weight bear. However, the person's mobility plan had not been updated to reflect this and stated they required a specific walking aid due to an injury and was able to weight bear.

● Staff told us they did not read people's care plans and were not able to provide any detail on people's life histories and backgrounds. One member of staff said, "No we don't read them. We look at the previous night on the handover." However, we reviewed the handover notes which had limited information.

● Daily care notes for people were often task focused and limited to whether the person was fine during the day and whether they ate all of their lunch. There was very little information on how staff engaged with people.

● End of life care plans were either not completed for people, had limited information or were not always followed. One person's care plan stated they had no family, yet their end of life care plan stated their wish was to have contact with certain members of their family. There was no record as to whether staff had taken any action to fulfil this wish.

Care and treatment was not always provided that met people's individual and most current needs. This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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.

● Care plans had records in place, so staff knew how best to communicate with people. However, staff were not always following this. One person's care plan stated they needed to have their hearing aids in and to wear their glasses. The person was not wearing either of these on the day of the inspection.

● The majority of people's care plans stated they preferred for staff to speak slowly and clearly. We observed there were staff that were not interacting in this way and people struggled to hear them.

Improving care quality in response to complaints or concerns

● There were varying responses from people and their relatives about whether they felt their complaints would be listened to. One person told us if they wanted to make a complaint, they would approach the

manager. They said, "I would go to her and tap on the door." However, a relative told us they had raised an issue a couple of times which they said had not been resolved.
● We reviewed the complaints folder and noted not all the complaints had a recorded response. There were other complaints where they had been fully investigated and the person contacted with a conclusion.

We recommend the provider ensures there is a record of investigation and conclusions where a complaint is made.

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 good. 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

- Since the last inspection there had been a change in registered manager. However, they left the service several months before we inspected. This left the deputy manager temporarily managing the service with support from the providers regional team whilst they recruited to a new manager who started in December 2022. This had an impact on the leadership and oversight of care.
- We found shortfalls during the inspection that had not been identified through provider visits to the service. Prior the inspection the provider sent us an action plan for October 2022. It stated they were to complete a full audit of care plans by 21 November 2022. We did not see evidence that had been completed. This would have identified the concerns we found including contradictory and out of date information on care needs and the mental capacity assessments concerns.
- Where shortfalls had been identified through audits, steps had not been taken to ensure robust action had been taken to address them. During an infection control audit in January 2023, it had been identified staff were seen to wear nail polish. We continued to see staff wearing nail polish on the day of the inspection.
- The provider medicine audit identified there were staff signatures missing from the medicine records and dates were not always on creams and eye drops when opened. We continued to find these gaps when we inspected.
- Throughout the inspection we observed a lack of cohesion between the staff teams on the floors. Each floor was had a team leader and, although there were allocation sheets so that staff knew who to provide care to, there were at time a lack of proactive direction from the seniors on the floor. The seniors on the floor were not seen to check whether staff had completed their tasks or directed to spend time with people in their rooms.
- Communication between the staff teams needed improvement. We noted where people were required to have fortified snacks or had chosen specific meals which the kitchen staff were not always providing. A member of staff told us, "It can be really annoying when people make choices and then it comes up as something different because they have had to change the menu." There was a lack of evidence this was followed up with the carers to the kitchen staff. Another member of staff said, "Sometimes there isn't good communication, not good teamwork."
- Team leaders on one of the floors tried to lead the day and positively direct staff. They were trying to encourage people to participate in activities and the atmosphere was joyful. However, when another member of staff was asked to sit in the lounge whilst we spoke to a team leader, the activity ceased and when we returned to the lounge people were going to sleep and there was a lack of engagement.

● Staff fed back they did not feel empowered in their role. One member of staff said, "The place has lost its oomph because there is a lack of enthusiasm. I've watched it slide since I started. It feels like we have lead boots on now." Another said, "I really loved the job, but this place is bringing me down."

Systems and processes were not established or operated effectively to ensure compliance with the requirements. This is a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The manager had started working at the service in December 2022. Whilst they had only been there a short time, they were already having a positive impact on the service. Comments from people and relatives about the manager included, "I had a chat with the person who runs this place, she made me a coffee. She is very nice. She hasn't been here long", "I have met the manager and she seems very nice and approachable" and "The new manager is doing an extremely good job. She is quite happy to sit you down and listen to you."
● Staff were also positive about the manager and felt things were starting to improve. Comments included, "The new manager seems good so I'm hopeful. If I ask a question, I get an answer not just a shrug or I don't know" and "I feel a lot more supported since the new manager started. I think she's listening. I'm hopeful."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● Residents meetings were taking place and people were updated on staffing, menus and activities. One person told us, "Yes I do go [to the meetings], they are quite useful. People can bring out their complaints." Another said, "They are useful to put our point of view over."
● Staff meetings also addressed areas for development and there was record on the minutes that staff were asked for their feedback on staff levels or anything that might impact their roles. One member of staff said, "The team leaders have daily meetings and monthly meetings for those on shift." We saw evidence of these meeting taking place.
● A recent food survey had been completed with people and the manager told us they were recruiting permanent chef and wanted to improve the meal experience for people.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The manager understood duty of candour and told us, "You need to be transparent. You need to be transparent with people and their families. If it is our fault, we need to put things in place. Not only with families, with CQC, safeguarding team. You pick it up and action it straight away."
● Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The provider had informed the CQC of significant events including incidents and safeguarding concerns.
● The manager and staff worked with external organisations that regularly supported the service. This included the local authority and health care professionals. One health care professional told us of the manager, "She is fantastic. She knows how to run a home. We have the Care Homes forum where we invite manager. Manager always attended; she is really proactive."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure care and treatment was always provided that met people's individual and most current needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure people were always treated with dignity and respect

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 the requirement of MCA and consent to care and treatment was followed

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure risks associated with people's care was always managed in a safe way

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

	The provider failed to ensure systems and processes were established and operated effectively to ensure compliance with the requirements

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure there was appropriate staff training, knowledge and competency checks