

Dementia Matters

Dementia Matters

Inspection report

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Date of inspection visit:

17 July 2023

25 July 2023

27 July 2023

Date of publication:

07 December 2023

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?

Inadequate 

Summary of findings

Overall summary

About the service

Dementia Matters is a care home providing accommodation and personal care for up to 10 people living with a mental health condition, learning disabilities and/or autism in one building. At the time of inspection there were 9 people living at the service. In addition to this care home, the service also provides a domiciliary care service to older people living in their own homes.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided. At the time of our inspection 12 people received the regulated activity of personal care in their own home.

People's experience of using this service and what we found

Care Home

Not all areas of the home were well maintained or clean and there were outstanding actions on the Legionella risk assessment. We also identified shortfalls relating to the maintenance of fire safety records. An effective safeguarding system was not fully in place. Prior to our inspection, a safeguarding allegation had not been referred to the correct agencies to ensure the appropriate action was taken. Records did not always demonstrate safe recruitment procedures had been followed. Medicines were not managed safely. An effective system was not fully in place to ensure there were sufficient staff deployed to meet people's needs and ensure the cleanliness of the home.

Records did not show how people's needs were assessed before they came to live at the home to ensure their needs could be met. Care records did not always show whether essential care tasks such as oral care had been carried out. An effective system to ensure staff were trained and supported was not fully in place. Records to evidence new staff had completed induction training were not always available. There were gaps in the provision of training including food hygiene. The design and décor of the home did not fully support people's dignity, orientation or wellbeing. Not all areas of the home were well maintained. Records did not fully demonstrate how staff were following the principles of the MCA.

Relatives spoke positively about the caring nature of staff. One relative told us, "Staff are friendly and caring and have a good sense of humour and are very attentive. The atmosphere is warm and welcoming with helpful admin staff."

Care plans did not always reflect people's needs. In addition, an effective system to review people's care and support needs was not fully in place. Records did not fully demonstrate how people's social and emotional needs were met. Several relatives told us they had raised a complaint/concern. Records relating to concerns and actions taken were not available.

An effective system to monitor the quality and safety of the service was still not fully in place. We identified shortfalls across many areas of the service which had not been identified by the providers quality monitoring system.

Domiciliary Care Service

An effective recruitment system was not fully in place. Records did not always demonstrate that safe recruitment procedures had been followed. Medicines were not managed safely. We identified shortfalls with medicines records. Risks were assessed and monitored. One relative raised concerns about infection control which we passed to management staff. Safeguarding systems were followed by staff. One relative said, "Never any sign of abuse, I can hear them with him, very chatty and friendly." There were enough staff deployed to meet people's needs. Relatives told us there were sufficient staff and the same staff provided care and support.

Relatives spoke positively about the caring nature of staff. One relative told us, "The quality of care and the staff are wonderful, there's not one of them who has not been considerate."

An effective system to ensure staff were trained and supported was not fully in place. There were gaps in the provision of training. Staff appraisal, supervision and competency checks had not been carried out as planned to ensure staff were supported in their job role. Information relating to consent was recorded in people's care plans.

People's needs were assessed. Most relatives told us that care and support was delivered in line with people's needs and choices. Records did not always evidence the number of complaints received and actions taken.

An effective system to monitor the quality and safety of the service was still not fully in place. We identified shortfalls which had not been identified by the providers quality monitoring system.

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

Rating at last inspection

The last rating for this service was requires improvement (published 9 May 2023). There were breaches of the 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 the provider remained in breach of regulations.

This is the second time the service has been rated requires improvement.

Why we inspected

We carried out an unannounced focused inspection of this service in December 2022 and January 2023. Breaches of legal requirements were found in relation to safe care and treatment, good governance and duty of candour. We also identified a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (notification of other incidents). The provider completed an action plan after the last inspection to show what they would do and by when to improve.

We undertook this inspection to check they had followed their action plan and to confirm they now met legal requirements. Prior to this inspection, we also received concerns in relation to the management of medicines and safeguarding allegations.

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 full report below.

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

Enforcement and Recommendations

We have identified 9 breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 during this inspection. These related to safe care and treatment, safeguarding people from abuse and improper treatment, premises and equipment, person-centred care, dignity and respect, recruitment, staffing, duty of candour and good governance.

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

We are also following up outside of the inspection process the provider's failure to ensure all notifiable incidents were reported to CQC. Full information about CQC's regulatory response to this is added to reports after any representations and appeals have been concluded.

Follow up

We will request an action plan and meet with management staff and the provider to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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?

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?

Inadequate 

The service was not well-led.

Details are in our well-led findings below.

Dementia Matters

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 3 inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type

Dementia Matters is a 'care home'. People in care homes receive accommodation and nursing and personal care as a single package under one contractual agreement dependent on their registration with us.

Registered Manager

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

A registered manager was in post.

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. We also contacted Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all this information to plan our inspection.

During the inspection

We spoke with 1 person who used the service. Most people who used the service were unable to speak with us due to the nature of their condition. Therefore, we carried out observations of care to help us understand people's experience. We also spoke with 12 relatives about their experience of the care provided. We received feedback from 16 members of staff including the registered manager, head of care, residential manager, a trustee, care staff, administrator and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records, this included elements of care records for 11 people including medicines records. We looked at the recruitment records for 3 staff and a variety of records relating to the management of the service, including policies and procedures. Following the inspection site visits we requested additional information by email and continued to seek clarification from the provider to validate the evidence we found.

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 requires improvement. At this inspection the rating has remained the same. 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; Preventing and controlling infection; Learning lessons when things go wrong

At our last inspection an effective system was not in place to ensure risks were identified, assessed and monitored. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Whilst some action had been taken to improve, further action was required and the provider remained in breach of Regulation 12 in relation to the Care Home service.

Care Home

- An effective system to ensure the maintenance, cleanliness and safety of the premises was not fully in place.
- Not all areas of the home were well maintained or clean and there were outstanding actions on the Legionella risk assessment. We also identified shortfalls relating to the maintenance of fire safety records.
- Records relating to falls management and accidents and incidents did not always demonstrate that management oversight and analysis had taken place. Lessons learnt had not always been documented.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our feedback, management staff explained that action was being taken in relation to all shortfalls identified and more robust checks had been commenced.

Domiciliary Care Service

- Risks were assessed and monitored. One relative raised concerns about infection control which we passed to management staff.

Systems and processes to safeguard people from the risk of abuse

Care Home

- An effective safeguarding system was not fully in place. Prior to our inspection, a safeguarding allegation had been made against a member of staff. The provider had not referred this allegation to the appropriate authorities to ensure the appropriate action was taken. After this information was shared with CQC we made the necessary referrals to ensure this information was appropriately responded to.

The failure to ensure an effective system was in place to ensure safeguarding allegations were appropriately reported, recorded and monitored was a breach of Regulation 13 (Safeguarding people from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Domiciliary Care Service

- Safeguarding systems were followed by staff. Relatives told us people were safe with the staff who supported them.

Staffing

At our last inspection we recommended that the provider reviewed staffing levels to ensure sufficient numbers of staff were available to meet people's needs. Not enough action had been taken and the provider was in breach of Regulation 18 [Staffing].

Care Home

- An effective system was not fully in place to ensure there were sufficient staff deployed to meet people's needs and ensure the cleanliness of the home.
- On our first visit, care staff carried out additional cleaning, laundry and cooking duties since there were no designated housekeeping/kitchen staff employed. Staff explained that carrying out these additional tasks was sometimes difficult. They said the appointment of housekeeping and kitchen staff would enable them to carry out their care duties effectively.
- We identified concerns with the cleanliness of the service and how people's social needs were met.

The failure to ensure an effective system was in place to ensure there were sufficient staff deployed was a breach of Regulation 18 [Staffing] of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our first visit, an agency domestic staff member was deployed Monday to Friday. Following our second visit and feedback, the head of care updated us to explain that a full-time housekeeper had been recruited to work Monday to Friday who would also have oversight of the kitchen duties. They also explained that most people accessed the provider's day centre through the week. We discussed with the head of care about staff deployment at the weekends when there was no day centre provision, domestic staff or senior management [although an on-call system was in place]. The head of care told us that this was being reviewed.

Domiciliary Service

- There were enough staff deployed to meet people's needs. Relatives told us there were sufficient staff deployed to meet people's needs and the same staff provided care and support. One relative raised concerns about the time/length of visits in relation to one staff member which we passed to management staff for their information.

Recruitment

At our last inspection we recommended that the provider reviewed their processes to ensure best practice guidance was followed when recruiting staff. Not enough action had been taken to improve and the provider was in breach of Regulation 19 [Fit and proper persons employed].

Care Home and Domiciliary Service

- An effective recruitment system was not fully in place. Records did not always demonstrate that safe recruitment procedures had been followed.
- Agency profiles were not fully available to evidence appropriate checks had been completed to assess the suitability of agency staff to work into the home.

The failure to ensure an effective staff recruitment system was in place was a breach of Regulation 19 [Fit and proper persons employed] of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

At our last inspection, an effective system was not in place to manage medicines. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough action had been taken to improve and the provider remained in breach of Regulation 12.

Care Home and Domiciliary Service

- Medicines were not managed safely. Further improvements were needed regarding handwritten entries and the records and guidance for topical medicines and medicines prescribed 'when required.'
- Guidance and records were not always in place to support the safe administration of topical medicines. We found that guidance was not clear for how often creams should be applied and some records were missing.
- Some people were prescribed medicines to be taken on a 'when required' basis or with a variable dose. Guidance for how these medicines should be administered was missing for some people. Where guidance required additional monitoring, this was not fully completed. The reason for taking a 'when required' medicine or the outcome was not always recorded to review effectiveness. This meant there was a risk people did not receive their medicines consistently.

The failure to ensure an effective system was in place to ensure records evidenced medicines were managed safely was a breach of Regulation 12 [Safe care and treatment] of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

Care Home

- An effective system was not fully in place to ensure best practice guidance was followed when assessing and providing care. We identified shortfalls in relation to the assessment of risk including infection control, medicines management, care planning and the care review process, meeting people's social needs and the Mental Capacity Act [2005].
- Records did not show how people's needs were assessed before they came to live at the home to ensure their needs could be met.
- Care records did not always demonstrate that personal care including oral hygiene had been carried out which meant we could not be assured that care had been carried out as planned.

The failure to ensure care and support was assessed and delivered in line with standards, guidance and the law was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Domiciliary Service

- People's needs were assessed. Most relatives told us that care and support was delivered in line with people's needs and choices. One relative raised concerns about several aspects of their family member's care which we passed to management staff for their information.

Staff support: induction, training, skills and experience

Care Home and Domiciliary Service

- An effective system to ensure staff were trained and supported was not fully in place. Records to evidence new staff had completed induction training were not always available. There were gaps in the provision of training including food hygiene.
- Staff appraisal, supervision and competency checks had not been carried out as planned to ensure staff were supported in their job role.

The failure to ensure an effective training and support system was in place was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our feedback, management staff explained that staff had been given a timescale for completion of mandatory training. In addition, they explained that the supervision and appraisal system was being reviewed.

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

At our previous inspection, we recommended that the provider reviewed best practice guidance to ensure the design and décor of the home meets people's needs, including those people living with dementia. Not enough action had been taken to improve and the provider was in breach of Regulation 15.

Care Home

- The design and décor of the home did not fully support people's orientation or wellbeing. Not all areas of the home were well maintained. One relative told us, "Standards have slipped over the last few months I feel, it is looking like an unloved type of place."

The failure to ensure the design and décor of the home met people's needs was a breach of Regulation 15 [Premises and equipment] of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

Care Home

- An effective system was not fully in place to ensure timely health advice was sought. There had been a delay in seeking medical advice following a deterioration in one person's condition.

The failure to ensure an effective system was in place to ensure timely medical advice was sought was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our feedback, management staff liaised with the care quality lead from the local Integrated Care Board with regards to implementing assessment tools, training and improved communication in this area.

Domiciliary Service

- Relatives raised no concerns about people's access to health care services.

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). When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

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.

Care Home

- Records did not fully demonstrate how staff were following the principles of the MCA.

The failure to ensure an effective system was in place regarding the management of DoLS applications was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Domiciliary Service

- Information relating to consent was recorded in people's care plans. One relative told us, "A power of attorney is in place...consent is always asked, and they are very respectful towards her."

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

Care Home and Domiciliary Service

- People were supported to eat enough to meet their nutritional needs.
- A recognised risk assessment tool was not used to help identify and manage the risk of malnutrition. We discussed this with management staff who informed us this would be addressed.

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 comprehensive inspection, we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people were not always well-supported, cared for or treated with dignity and respect.

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

Care Home

- Records did not always evidence how people and relevant others were involved in their care. In addition, records did not fully evidence that any decisions made in people's best interests had been assessed in line with the MCA and the appropriate individuals had been involved.

The failure to ensure records demonstrated how people were involved in their care and support was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Domiciliary Service

- Relatives told us they were involved in people's care. One relative said, "I'm involved with her care plan, it's all done properly and updated."

Respecting and promoting people's privacy, dignity and independence

Care Home

- Staff practices did not always promote people's privacy, dignity and independence. For example, people's bedroom doors were locked so they could not access their room unless staff opened the door.
- One person's clothing was stored in the laundry room rather than in their bedroom. Records did not evidence why it was assessed this person could not have direct access to their clothing.
- Timely action was not always taken to support one person who regularly declined support with their personal care. This impacted their appearance and dignity. Records did not evidence the actions staff had taken to assess this.
- The environment, furnishings and cleanliness did not fully promote people's dignity, independence and wellbeing. For example, on the first day of the inspection we reported there was a strong malodour from an item of furniture. On the third day of the inspection we highlighted to management this issue had still not been addressed.

The failure to ensure people's dignity, privacy and independence was promoted was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Management staff were working with local businesses with regards to improving the environment. They were also liaising with the local NHS infection control team and implementing their recommendations.

Domiciliary Service

- Relatives told us staff were respectful. One relative told us "They are all respectful and we feel safe in their company. Their attitude towards me is supportive as well and they treat me with respect as well."

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

Care Home and Domiciliary Service

- Relatives spoke positively about the caring nature of staff. Comments included, "I have watched the way they are with her; they are very caring and warm to the residents and each other" and "She loves them and engages with them. Her communication is much improved as has her life. I can't praise them enough; she can have a laugh and joke." Staff also spoke positively about the people they supported.

Is the service responsive?

Our findings

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

At our last comprehensive inspection, we rated this key question good. At this inspection the rating has changed to 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; Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

Care Home

- An effective system to ensure people's emotional and social needs were met was not fully in place. Records did not fully demonstrate how people's social and emotional needs were met.
- Care plans did not always reflect people's needs. In addition, an effective system to review people's care and support needs was not fully in place.
- Records relating to people's end of life wishes were not in place.

The failure to ensure people's support met their needs and reflected their preferences was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Following our feedback, management staff wrote to us and explained that care plans were being updated and weekly reviews of people's care and support were being carried out. Management staff were liaising with the local palliative care educational facilitator with regards to end of life care.

- People's relatives and friends were able to maintain contact and visit. One relative told us, "I can visit anytime and am always made welcome."

Domiciliary Service

- Care was planned to meet people's needs. One relative told us, "Care plan is discussed and updated. There's a form to fill in with family information and their likes and dislikes."
- People were supported to access the local community where this was part of their plan of care. One relative told us, "They all know him, and we have confidence in them, they take him out for trips to garden centres and coffee. They tailor trips to his likes. They all know what they are doing and deserve a gold star for what they all do for him."

Improving care quality in response to complaints or concerns

Care Home and Domiciliary Service

- An effective system to ensure records evidenced the number of complaints received and actions taken was not fully in place. Several relatives told us they had raised a complaint/concern. Records relating to

concerns and actions taken were not available.

The failure to ensure records were in place to demonstrate how complaints were responded to and actioned was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Meeting people's communication needs Care Home and Domiciliary Service

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.

- An accessible information policy was not in place to state how the service implemented the requirements of the AIS. Following our feedback, management staff wrote to us and explained they were using a care management service who had provided them with relevant up to date policies and procedures which were going to be implemented following ratification by the board of Trustees.

Is the service well-led?

Our findings

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

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection, an effective system was not fully in place to monitor the quality and safety of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014. Not enough action had been taken and the provider remained in breach of Regulation 17.

Care Home and Domiciliary Service

- An effective system to monitor the quality and safety of the service was still not fully in place. We identified shortfalls across many areas of the service which had not been identified by the providers quality monitoring system.

The failure to ensure an effective system was in place to monitor the quality and safety of the service was an ongoing breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At our last inspection an effective system was not fully in place to ensure events at the home were notified to CQC in line with legal requirement. Not enough action had been taken and this is being followed up outside of the inspection process.

Care Home

- An effective system was still not in place to ensure events at the home were notified to CQC in line with legal requirements.

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 the last inspection, a system was not in place to ensure the requirements of the duty of candour were met. Not enough action had been taken and the provider remained in breach of Regulation 20 [Duty of Candour].

Care Home

- Records did not demonstrate how the provider was meeting their responsibilities under the duty of candour.

The failure to ensure records demonstrated how the provider was meeting their responsibilities under the duty of candour was a continuing breach of Regulation 20 [Duty of candour] of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Domiciliary Service

- No notifiable safety incidents which required the provider to act under the duty of candour had been notified to us.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

Care Home and Domiciliary Service

- Several staff talked about a negative culture at the service which they described as one of blame and not one that always encouraged learning and reflection.
- An effective system to engage and involve people and relatives in the service was not fully in place.

The failure to ensure an effective system was in place to involve people and relatives in the service and make sure there was a positive culture which promoted positive outcomes for people was a breach of Regulation 17 [Good governance] of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Working in partnership with others

Care Home and Domiciliary Service

- Staff were working with external stakeholders such as the NHS infection control team and local integrated care board who were supporting them to make the necessary improvements.

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 An effective system to ensure people received personalised care or that people were fully involved in the decision making process regarding their care and support. Regulation 9 (1)(3)(a)(b)(c)(d)(f)(g)(h)(i)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Effective systems to ensure people were always treated with dignity and respect was not in place. Regulation 10 (1)(2)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment An effective system was not in place to assess, monitor and mitigate risks relating to the health and safety of people. Medicines were not managed safely. Regulation 12 (1)(2)(a)(b)(g)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment An effective safeguarding system was not in place. Regulation 13 (1)(2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 15 HSCA RA Regulations 2014 Premises and equipment</p> <p>The provider had ensured the premises and all equipment had been adequately maintained. Regulation 15 (1)(a)(e)(2)</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Personal care	<p>An effective system was not in place to ensure compliance with the regulations. The governance systems in place were not robust enough to identify shortfalls in quality and safety. Regulation 17 (1)(2)(a)(b)(c)(e)(f)</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed
Personal care	<p>Effective systems to ensure staff were recruited safely was not in place. Regulation 19 (1)(2)(3)</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour
	<p>An effective system to ensure the Duty of Candour principles were met was not in place. Regulation 20 (1)(2)(3)(4)(5)(6)</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Personal care	<p>An effective system to ensure sufficient numbers of suitably skilled, competent and supported staff were deployed, was not fully in place. Regulation 18 (1)(2)(a)</p>

