Teignbridge House Care Home Limited

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Inspection report

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Date of inspection visit:
10 May 2023
17 May 2023
22 May 2023
23 May 2023

Date of publication:
14 July 2023

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
The care home is registered for 24 people, including people living with dementia. At the time of our inspection there were 22 people living at the home, which includes people on intermediate care stays. The registered manager is also the nominated individual.

People's experience of using this service and what we found
During the inspection a number of concerns were identified and shared with the provider while we were on site. The provider took the concerns seriously and has worked alongside CQC and other agencies to address the issues.

Repeat breaches of the regulation linked to safe care and treatment indicated lessons were not being learnt by the provider. During this inspection, we also found new breaches in other areas of care, such as safeguarding and recruitment, which showed a deterioration in the management of the service.

The provider failed to ensure risks to the health and safety of people were assessed and that all reasonably practicable steps were taken to mitigate those risks. They failed to ensure the environment was safe with shortfalls identified in both fire safety and infection control putting people at risk of harm. We also found people identified at risk of dehydration and malnutrition were poorly monitored as records were incomplete and not reviewed. One person at risk of pressure damage was at increased risk through equipment not being appropriately used.

The provider was not proactive in responding to examples of potential abuse and had not recognised when to report a safeguarding concern. Medicines were administered appropriately but systems linked to management and auditing needed improvement.

Staff recruitment did not ensure candidates were suitable to work in care, and the staffing levels were not based on an assessment of people's care and emotional needs. Staff said they struggled to meet people's care needs in the afternoons because of the staffing levels, and people told us staff were too busy to stop and chat. This particularly impacted on people who chose to stay in their bedroom.

People were at potential risk because the provider failed to ensure staff received appropriate support, training, and professional development. The competency of new staff was not assessed to ensure they were safe and knowledgeable in their practice. Staff did not receive appropriate support and supervision to enable them to carry out duties they were employed to perform.

Care plans for people living with dementia did not contain records of best interest decisions or mental capacity assessments. In people's care plans consent to care was not routinely recorded.

People were not supported to have maximum choice and control of their lives and staff did not support

them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

People's individual tastes and dietary preferences were catered for. Catering staff met with people when they moved into the service to ensure they knew their likes and dislikes. Relatives commented staff went the "extra mile" trying different dishes to tempt people who ate little and supplemented meals with snacks, ice cream, fruit, and ice lollies.

It was not always clear from care records or handover records whether health professionals had been consulted or what action was being taken. However, people told us staff knew them well and would notice if they were ill or in pain. For example, one person said, "They do know your needs and will do what they can to help. They know if I'm unwell." Relatives were confident staff would liaise with other health professionals to ensure people received the treatment they needed.

People's dignity was not always preserved. People's clothes and laundry were lost or given to the wrong person. For example, a relative said, "There have been a couple of tops gone missing and we have gained a few…" Other people and relatives said it was an on-going problem.

However, people told us the staff were caring and friendly. They felt safe as staff regularly checked on their well-being. For example, they said, "Good food, good staff…My family are happy with the care. I feel I'm spoilt." Relatives said staff had a kind way of speaking to people and one described the "wonderful relationship" their mother had with two particular care staff. Another described how they had been so attentive during a rapid decline in health for their relative. Relatives wrote, "She could not have had better care anywhere" and "We are all eternally grateful for your excellent care."

Care plans did not contain information about how care staff should respond to peoples' emotional needs. Guidance was not in place for staff to support people's anxiety or mental health needs. However, we saw people's end of life wishes were recorded and contained personal details. At the time of the inspection, there was no one receiving end of life care. Conversations with staff showed they knew people well. For example, explaining the actions they would take to support an individual with declining communication, including monitoring their pain levels through their actions and vocal sounds.

People's complaints were not effectively addressed because there was not a meaningful complaints process. People and relatives told us there were on-going problems with the management of laundry. We checked the complaints file; there was no record of any complaints linked to laundry.

The provider did not have effective oversight of the care provided and the running of the home which meant they failed to comply with regulations, so people were at risk of harm. This meant they also failed to implement improvements at the service in a timely manner.

However, people were generally pleased with the care and said they would recommend it to others. For example, they said, "I wouldn't go anywhere else. I like it here…", "I've been very fortunate to come here" and "On the whole I like it here but there is room for improvement." Visitors said they had "peace of mind" knowing their relatives was happy and safe. For example, they said, "I think it's all very good. The staff are good" and "They genuinely care about my mother…I can go to bed knowing she is cared for."

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

Rating at last inspection and update

The last rating for this service was requires improvement (published 11 November 2019). 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 2 regulations and there were also new breaches of other regulations.

Why we inspected
This inspection was prompted by a review of the information we held about this service.
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.

This inspection was carried out to follow up on action we told the provider to take at the last inspection. It was originally a focused inspection which we expanded to a comprehensive inspection on the first day due to the level of concerns.

The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection. You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement
We have identified breaches in relation to safe care and treatment, staffing deployment, training and recruitment, consent, person centred care, complaints and governance.

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

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

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Teignbridge House Care Home Limited

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 conducted by 1 inspector, a medicines inspector, an assistant inspector, and 2 Experts 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
Teignbridge House Care Home Limited 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. Teignbridge House Care Home Limited 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 a registered manager in post, who was also the nominated individual and the provider. A nominated individual is responsible for supervising the management of the service on behalf of the provider. After the inspection the provider told us they planned to retire from the role of registered manager and planned to recruit a new registered manager. In the meantime, they have hired a consultant to help address the issues raised at the inspection.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

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

During the inspection
We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who may not be able comment directly on their care.

An Expert by Experience spoke with 10 people living at the home on 10 May 2023, and 6 relatives on 11 May 2023, to gain their feedback on the service.

We spoke with 8 staff and gave the staff group an opportunity to respond to us by e-mail. We received 8 responses. We spoke with the registered manager who was also the provider. We reviewed a range of records. This included 5 people's care records and people's medication records. We looked at 3 staff files in relation to recruitment and looked at records relating to staff supervision and training. We reviewed a variety of records relating to the management of the service, including minutes from staff meetings, handover notes, audits and rotas. We completed a tour of the building.

On each day of the inspection, we gave verbal feedback during the day to the provider and the management team. We also sent e-mails detailing our most significant concerns and requesting evidence of action being taken to address them.

The inspection concluded on 23 May 2023 when verbal feedback was provided to the provider and the management team. CQC has worked with other agencies including safeguarding, commissioners, health professionals and the fire service to monitor people's safety. Following the inspection, the provider hired a consultant to address the concerns raised at the inspection. This work started on 3 June 2023.

Inadequate

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management
At our last 2 inspections the provider had failed to robustly assess the risks relating to the health, safety and welfare of people. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- The provider failed to ensure risks to the health and safety of people were assessed. They failed to ensure the environment was safe and therefore put people at risk of harm. For example, cleaning chemicals were left in reach of people living with dementia, which potentially put them at risk of harm.
- On the first day of the inspection, there was no record of fire training for staff in 2022 and 2023, apart from for 1 staff member. The provider confirmed it was their responsibility to organise staff fire training and this had not taken place. They told us the emergency lights had not been checked since 2021, which records confirmed.
- The Fire Risk Assessment was dated 2019 and had not been reviewed since this time. The fire logbook was missing key pages, which was confirmed by a fire safety contractor on 17 May 2023. This meant there was no record of the position of fire extinguishers in the care home. There was no record the fire extinguishers had been checked to ensure they were in safe working order. The provider said they had completed work to meet fire service standards but had no record of this work. There were no assessments for fire risks linked to external medicinal preparations.
- There was poor practice around pressure care for people who were at risk of skin damage. For example, one person with a pressure sore was sitting on a deflated pressure care cushion making it ineffective. Staff said the person required 2 hourly repositioning when in bed. In the staff communication book dated 1 February 2023, staff were reminded to turn the person. We asked to see the repositioning records for this type of care; we were told by staff there were none. This meant the person was at potential risk of further pressure damage.
- People were at risk of harm because staff did not effectively monitor their fluid intake. For example, people were assessed as at risk of dehydration and a fluid chart had been implemented. However, there was no daily fluid target and amounts were not totalled at the end of each day, making the monitoring tool meaningless. There were also records of significant gaps between drinks.
- People were at risk of harm because staff did not effectively monitor their food intake. For example, even where a person had been referred to a dietician due to their risk of malnutrition, there were multiple gaps in records of food intake.
- We were told risks to people were highlighted at staff shift handovers. However, when one person's food

and fluid intake was low, we saw no handover records were written on that day or the day after. This meant there was no record of all staff being aware of this risk and what action was proposed to minimise it.
● A Health and Safety Risk Assessment for the environment completed on 16 May 2018 had not been reviewed. The risk of the front door being unlocked between 8am and 4pm was categorized as low. However, there was no reference to people living with dementia potentially leaving the building without staff knowledge. Or subsequently the risk of harm from the nearby main road, and potential falls on the step driveway, which had not been identified in the risk assessment.

Risks were not always identified, monitored or mitigated. This potentially placed people at risk of harm. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● On the second day of the inspection, we saw improvements had been made to the food and fluid charts and the way staff were completing them. Staff recognised they needed to make them meaningful. For example, goals were added and were to be monitored daily with action taken where risks were identified. Following our feedback, they had assessed additional people as needing this type of monitoring.
● On the second day of inspection, a fire safety contractor visited the service to address concerns raised on our first day, and supply staff training.
● Staff told us they were reviewing who needed regular re-positioning to ensure there was a consistent approach to pressure care.

Preventing and controlling infection
At our last 2 inspections the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● We were not assured the provider was supporting people living at the service to minimise the spread of infection. There was a strong unpleasant odour on the landing of the first floor outside and inside a bedroom. There were brown stains on the carpet. The provider said the person experienced a medical condition, which resulted in faecal accidents, and the carpet was cleaned several times a week. However, additional action had not been taken to consider replacing the flooring or ensuring the person's chair was regularly cleaned.
● Staff practice showed they did not consider the risk of cross infection when they walked around the home wearing gloves. Gloves should be discarded after each care activity for which they were worn and before contact with other items such as door handles. This meant there was a risk of cross infection. We saw staff giving people biscuits by hand and placing them directly on surfaces which did not look clean. For example, a side table by a commode.
● We were not assured the provider was promoting safety through the layout and hygiene practices of the premises. We saw furniture was stained, for example, a communal chair in the lounge and the base of a specialist chair was encrusted with food.
● We were not assured the provider was preventing people from catching and spreading infections. A yellow waste bag containing used incontinence pads was left open on the floor on the first floor landing. We pointed this out to the provider, but they did not close it or find a staff member to remove it.

Systems had not been established to assess, monitor and mitigate some risks to the health, safety and

welfare of people using the service. This potentially placed people at risk of harm. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
At our last 2 inspections the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● Improvements were needed to the way 'when required' medicines were managed. Staff recorded on Medication Administration Record (MAR) charts if doses were given. However, the time of administration was not always recorded. This could lead to the risk of doses being given too close together.
● Medicines were stored securely. Storage temperatures were recorded daily to make sure medicines were stored correctly. However, the maximum and minimum temperature range in the refrigerator was not recorded, and there was no record of actions taken if the temperature was recorded out of the required range. This is not in line with the home's policy or best practice guidance.

Systems had not been established to assess, monitor and mitigate some risks to the health, safety and welfare of people using the service This potentially placed people at risk of harm. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff recorded when people's medicines were administered on MAR charts. These records showed that people's medicines were given as prescribed for them. This also included the application of creams and other external preparations.
● People were positive about the way their medicines were administered by staff. They told us they were on time, and they could ask for painkillers, when necessary. Relatives were confident in how medicines were managed by staff and told us they were kept informed of changes, for example changing to a liquid format rather than a tablet. Relatives said staff recognised changes in people and liaised appropriately with health professionals for the person's medicine to be reviewed, for example for anxiety.

Systems and processes to safeguard people from the risk of abuse
● The provider failed to protect people from abuse or improper treatment. They did not ensure safeguarding concerns were reported externally.
● One person expressed unhappiness at their appearance, which we saw had been neglected. They were reliant on staff to advocate for them as their actions and communication indicated they were living with dementia and had few visits from family or others. There was no record of the GP being contacted for advice by staff; we made an individual safeguarding alert to the local authority.
● During our inspection, we followed up on concerns about the well-being of one person and their treatment by some staff, including the actions of one staff member. We made an individual safeguarding alert to the local authority and informed the provider, who did not address the allegations linked to one staff member. There was also no record of a fall experienced by the person.

The provider did not ensure safeguarding concerns were addressed. This potentially placed people at risk of harm. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Most people told us they felt safe because the staff checked on them regularly and answered their call bells. For example, they said, "It's OK, I've settled in quite well, I feel safe" and "It's very good, excellent, the staff look after me very well. I've no complaints."
● People told us others living at the home came into their room uninvited, although they commented the main person had since moved away. They were not alarmed but called staff to assist the person out of their room, which they said staff did in a kind and gentle way. However, one person said they had complained about the intrusion and said they had just been told to keep their door shut which they did not want to do.

Staffing and recruitment
● The provider failed to ensure recruitment was safe and therefore put people at risk of harm as they did not ensure candidates were suitable to work in a care home setting. Staff records showed there were gaps in a staff member's employment history. These had not been explored with the applicant so the reasons for the gaps had not been recorded.
● There was not satisfactory evidence of candidates conduct in previous care home employment. This is because the candidates' work colleagues rather than their manager or employer had been contacted for a reference.

The provider did not ensure fit and proper persons employed. This potentially placed people at risk of harm. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● However, police checks had been applied for in a timely and appropriate manner. People were positive about the staff group, calling them "respectful" and "very nice." However, some said there had been a staff member who had been abrupt and was not a "people person."
● There was insufficient staff deployed in the afternoon and evening. The staff rotas showed after 2pm, there were 3 care staff on duty. The provider did not use a staffing tool to assess how many staff were needed for the care needs of people living at Teignbridge House Care Home Limited and did not deploy staff based on people's needs. For example, staff told us told us 6 people required 2 staff to move them and 3 people had moving and handling needs were variable. Some people were living with dementia, and we saw how their emotional needs increased later in the afternoon which impacted on staff availability.
● Staff told us staff deployment was problematic, for example "Afternoons are hard especially when we are short staffed and it's still the same amount of work that needs doing in the morning…the staff numbers go down in the afternoon to 3, even some shifts to 2 staff, but the care and needs of the residents don't change…"
● At the time of our inspection, there was no cleaner on the rota to work at weekends. Staff told us they struggled to complete cleaning tasks on top of providing care at weekends. Staff told us they had raised concerns with the provider regarding the afternoons but there had been no changes made.
● The management team did not have an effective system to monitor if there were enough staff on duty to meet people's needs. The type of call bell system and it's placement in the building did not facilitate this. The management team's office was in the basement; a call bell display screen had not been installed in their office. This meant they could not effectively monitor whether the deployment of staff met people's care needs.

The provider did not ensure there were sufficient numbers of staff who were suitably qualified, competent, skilled and experienced. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

● Repeat breaches of the regulation linked to safe care and treatment indicated lessons were not being learnt by the provider. During this inspection, we also found new breaches in other areas of care, such as safeguarding and recruitment, which showed a deterioration in the management of the service.

Inadequate

Is the service effective?

Our findings

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 inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience
- People were at potential risk because the provider failed to ensure staff received appropriate support, training, and professional development.
- There was a failure to ensure new staff received appropriate support, induction and professional development. There was no inclusion of the Care Certificate standards to promote best practice. The competency of new staff was not assessed to ensure they were safe and knowledgeable in their practice.
- Staff did not receive timely supervision to promote their professional development and ensure they were well supported.
- We asked for staff training records. There was no clear system to collate the training staff had undertaken. Therefore, the provider could not identify if staff working at the home had the appropriate training, including dementia awareness or infection control. Actions by some staff indicated a lack of training or updates on training. For example, poor infection control practice and lack of dementia awareness.
- Staff received training for medicines administration, and this had been updated recently for staff. However, competency assessments were not renewed in line with best practice guidance and needed updating.

The provider had failed to ensure staff were suitably qualified, competent, skilled and experienced. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People commented there were not enough staff and gave examples of staff not having time to engage with them individually. One person noted staff seemed to struggle with more complex people. However, people said they felt well cared for and could have a bath or shower when they requested it. Several people told us they felt safe when staff moved them using a hoist. For example, they said, "When I am being hoisted, I am confident they know what they are doing."
- A health professional said some of the staff, including catering staff, had actively engaged in nutritional training and how it could benefit the people they looked after. However, we saw from the poor monitoring and completion of food and fluid records that this training had not been translated into practice.

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.

● Care plans for people living with dementia did not contain records of best interest decisions or mental capacity assessments.
● The provider failed to ensure people's rights were upheld to consent to care according to the law. In people's care plans consent to care was not routinely recorded. We saw staff had recorded one person had 'become agitated' with personal care and transfers by 'hitting out and swearing at staff. This had been reported to management.' There was no record of a best interest decision for the person to receive personal care where they lacked capacity to make the decision themselves.
● The provider failed to complete Mental Capacity assessments for people living at Teignbridge House Care Home Limited. This included whether people had the capacity to decide where they wished to live or whether equipment was used, such as bed rails. This meant people's capacity to consent to their care was disregarded. This left people at risk of unlawful restraint and deprivation of their rights, and of not receiving care which might have been in their best interests.

The provider had failed to ensure people's rights were protected. This was a continued breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had ensured they had copies of lasting power of attorney (LPA) linked to health and welfare and/or finances. A LPA is a legal document that lets the 'donor' appoint one or more people (known as 'attorneys') to help them make decisions or to make decisions on their behalf. This helped protect people's rights. We also saw appropriate DoLS applications had been made for some people.

Adapting service, design, decoration to meet people's needs
● People told us some people living with dementia were disoriented and came uninvited into their room. We saw none of the bedroom doors had names or identifying features on them, apart from a number. The provider told us the reason for this, their answer showed they had misunderstood the principles of data protection. We also saw the door numbers did not follow in sequence, for example Room 23 and then Room 31. The provider explained this was due to an extension being built. These factors did not enable people to find their way around the building.
● Some areas of the home, for example, the first floor landing looked tired because the wallpaper and the paintwork needed refreshing due to damage.
● There was no passenger lift which meant people living on the first floor needed to be able to use a stair lift if they wished to use the communal areas of the home.

Supporting people to eat and drink enough to maintain a balanced diet
● There was a lack of clarity as to why some people had their food prepared in a specific way, such as being

pureed or cut up smaller. Staff said this would be reviewed by contacting health professionals for advice.
● People's individual tastes and preferences were catered for. Catering staff met with people when they moved into the service to ensure they knew their likes and dislikes.
● Staff were also aware of people's allergies, which we saw when a milkshake was being prepared, and an adaptation was made for one individual. We saw people enjoyed snacks and drinks provided in between meals. There were menus and people were offered a choice.
● Relatives commented staff went the "extra mile" trying different dishes to tempt people who ate little and supplemented meals with snacks, ice cream, fruit and ice lollies.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
●The provider did not discuss with commissioners the level of care needs of people living at the home, and this question was not asked when the local authority made enquiries for people to move permanently or for intermediate care.
● The provider said a dependency tool was not used when they assessed people considering moving to the home. This meant there was a lack of consideration as to the impact of people with high care needs moving to the service. There was a lack of oversight as to how many people had additional care needs. For example, because they needed equipment to move or because they had high levels of anxiety or were living with dementia.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● It was not always clear from care records or handover records whether health professionals had been consulted or what action was being taken when people were unwell.
● However, people told us staff knew them well and would notice if they were ill or in pain. They said staff contacted the GP and if necessary, rang for an ambulance. For example, one person said, "They do know your needs and will do what they can to help. They know if I'm unwell."
● Relatives were confident staff would liaise with other health professionals to ensure people received the treatment they needed. They gave specific examples, including the role of occupational therapists and the mental health team in the care of their relative.
● Health and social care professionals said they did not have concerns about the health or well-being of people living at the home. This was confirmed during a safeguarding meeting.

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.

Supporting people to express their views and be involved in making decisions about their care;
● People were not supported to express their views. For example, records did not show they were involved in reviewing their care plans. Where updates had been made to care plans, they were not always dated, which made an accurate review of changes difficult. For example, reviewing whether the use of bed rails had been successful in keeping a person safe.
● People were not given a regular opportunity to express their views about the home through regular meetings. An annual survey was given to people, but the results and actions were not shared afterwards. The last residents' meeting was in December 2022.

The provider did not ensure all aspects of people's care was personalised and met their emotional and social needs. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Respecting and promoting people's privacy, dignity and independence; Ensuring people are well treated and supported; respecting equality and diversity
● People's dignity was not always preserved. People's clothes and laundry were lost or given to the wrong person. For example, a relative said, "There have been a couple of tops gone missing and we have gained a few…" Other people and relatives said it was an on-going problem.
● One person's care plan recorded their faith was important to them and enjoyed the visits from people from the local church. One staff member was given the role of organising a trip to the church if the person requested it. However, there was no record to show if the person had been asked if their faith needs were being met.
● However, people told us the staff were caring and were friendly. They felt safe as staff regularly checked on their well-being, including during the night, which they said reassured them. For example, they said, "Good food, good staff…My family are happy with the care. I feel I'm spoilt."
● We saw caring and thoughtful interactions by some staff members. For example, the activity staff member took time to try and include everyone in the sun lounge with a range of activities. They were also good at recognising when a person became restless and subtly directed them to the toilet. And we saw they spent time reassuring a person who was becoming anxious.
● Relatives said staff had a kind way of speaking to people. One person described the "wonderful relationship" their mother had with 2 particular care staff. Another described how they had been so attentive when their relative's health had rapidly deteriorated. They also commented on how important the regular hairdresser visit was to their relatives' sense of well-being and dignity.

● Relatives described the thoughtfulness of staff, one visitor described how their relative had been "very afraid" of the hoist in their room describing it as a "grey lady at the end of her bed." They said staff listened and changed the hoist to a new white one, which their relative was not concerned about. They said, "I was impressed by that. They genuinely care about people."

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

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

● Care plans lacked personalised information as to how people wished to be supported with personal care and social support.

● People were not consistently asked if they had a preference regarding whether a male or female member of staff provided personal care to them. Care staff confirmed this question was not always asked.

● Care plans did not contain information about how care staff should respond to peoples' emotional needs. For example, the focus in 1 person's care plan was on their family's emotional support but they were only able to visit once a fortnight. Therefore, on other occasions it was the staff group who the person would be reliant on when they became distressed, and there was no guidance on how to respond to their emotional needs.

● Guidance was not in place for staff to support people's anxiety or mental health needs. In 1 person's care plan under the title 'Behaviour' it said, 'X often calls and shouts out stating that we are hurting her mother during these time staff to offer support and reassurance.' However, there was no further advice as to what type of approach worked to calm the person and to help provide a consistent approach. We saw some staff did not routinely reassure people who became anxious during transfers. We also saw a staff member abruptly lifted a person's legs to place them on the footplates of the wheelchair; the person expressed pain at this action.

The provider did not ensure people's care was personalised and met their emotional and social needs. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We saw people's end of life wishes were recorded and contained personal details. At the time of the inspection, there was no one receiving end of life care. However, a visitor described how their relative had been very unwell and how the staff had said they would not give up on them. They felt strongly the care and attention from staff had enabled their relative to recover and said, "I can't praise them enough for that."

● Conversations with staff showed they knew people well. For example, explaining the actions they would take to support an individual with declining communication, including monitoring their pain levels through their actions and vocal sounds.

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

● Care staff told us while the activities coordinator had been on long term sickness leave there was no record of how social needs had been met.

● We met with people who chose for various reasons to stay in their room. People told us they wanted

company and conversation rather than specific activities. For example, they said, "There's not much going on…The staff don't have the time to chat", "They are busy, I'd like them to talk" and "They don't stop and chat, they are too busy."

The provider did not ensure people's care was personalised and met their emotional and social needs. This was 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.
● Staff had not been reminded or taught to remember the communication needs of people living with dementia. We saw some care staff did not take time to engage with people before encouraging them to move. This meant the person was not given the time to understand the task and was not treated as an equal. For example, several transfers we observed were rushed.

The provider did not ensure people's care based on their assessment of their needs and preferences. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● However, we saw in one person's care plan, staff were reminded to turn on the subtitles for them so they could enjoy watching television because of their hearing loss.
Improving care quality in response to complaints or concerns
● People's complaints were not effectively addressed because there was not a meaningful complaints process.
● People told us there were on-going problems with the management of laundry; this was also raised in a meeting in 2022. People told us, "I've had £150 worth of clothing go missing in the laundry, nightdresses, underwear", "I've had stuff go missing in the laundry, but I got them back eventually" and "I have had 8 T-shirts and 8 brand new boxer shorts go missing in the laundry. I'm wearing boxers that don't belong to me. I constantly complain about it, and they say they can't find them."
● Relatives have raised complaints about missing laundry, for example, "The only problem is his clothes go missing. … Clothes have gone missing already. His vests went missing, they sort his vests out, then his socks go missing, I can't mark his socks. I don't know what it is that makes his clothes go missing." And "The thing I have raised is the washing, socks seem to go in a hole somewhere." In the staff communication book on 1 May 2023, staff wrote '(X's) son asked where all (X's) clothes had gone…I said I would look in the laundry but nothing there, they have all got room number on.'
● We checked the complaints file; there was no record of any complaints linked to laundry logged in the file. The provider and other staff members said this was where complaints would be logged. There was no log of actions to address complaints linked to missing or damaged laundry.
● Staff told us they had raised concerns about staffing levels in the afternoon. These were not logged, and staff said their concerns had not been addressed regarding not being able to meet people's care and emotional needs. Some staff did not feel listened to, for example "I just feel like you say something, it is always, we'll do it tomorrow or it won't get done or we didn't know, and I think you did know because we told you…"

The complaints process was not effective to ensure a meaningful response to complaints. This was a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Despite the above, people and relatives said staff and the provider were approachable and helpful. Staff confirmed the provider was accessible and could be approached with concerns. They commented the provider was kind if they had personal issues or difficulties.

● Some people told us complaints had been resolved. For example, they said a call bell had been left out of reach of their relative on several occasions despite the issue being raised with the provider and the management team. The relative said they raised the issue again and said they wanted the matter taken seriously. They told us they were happy with the outcome and in their view "Actions are always put right when you talk to them." However, there was no log in the complaints file regarding this issue and it had taken several complaints by the relative for the issue to be addressed.

Inadequate

Is the service well-led?

Our findings

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

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

At our last 3 inspections the provider had failed to ensure there was good governance at the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

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

- The provider did not have effective oversight of the care provided which meant they failed to comply with regulations, so people were at risk of harm. This meant they failed to implement improvements at the service in a timely manner.
- The provider was also the registered manager. Additionally, they were the nominated individual, whose role includes oversight of the quality assurance standards in the home. The outcome of this inspection showed this was not an appropriate arrangement because of the number of breaches of regulation.
- An assistant manager and a deputy manager managed the home on a day to basis. They met regularly with the provider but there was no record of regular supervision or an induction into their roles. A staff member commented the 2 staff members had been "thrown in the deep end."
- There was a failure to ensure there were effective systems and processes to monitor the work and performance of staff. On the office wall there was a list under each member of the management team as to who managed which tasks, for example, recruitment. However, there were no arrangements to check how each person was managing their tasks. This meant the issues we identified during the inspection had not been picked up and addressed through quality assurance by the provider.
- There was poor oversight of the work of seniors, for example, written handover records not being completed. Seniors did not oversee the completion of other records by staff, such as food and fluid charts. This meant there was poor oversight of identified risks and risks were not acted on.
- There were poor governance arrangements and oversight. This meant the risks of malnutrition, dehydration, lack of mental and emotional stimulation, poor infection control, staff training and environmental risks had not been identified or addressed.
- People were at potential risk because the service's systems and processes failed to identify some aspects of medicines were not being managed safely. Medicine audits took place, but they were not effective as areas for improvement found on our inspection had not been identified. This left people at risk of harm.
- There were poor systems or processes in place to ensure staff were recruited appropriately. There were gaps in their employment history which had not been addressed and there was a poor choice of references.

Therefore, steps were not taken ensure the staff team were suitable to work with in a care home.

Systems were not effective to ensure good governance of the service. This placed people at risk of harm. This was a repeated breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Systems failed to identify people did not always receive person centred care. Quality assurance processes had failed to address the fact there was a lack of stimulation for people at the home, including those cared for in bed or choosing to stay in their room. There was a considerable risk of people becoming withdrawn due to lack of social stimulation.

● There was a failure to ensure there were systems and processes in place to protect people from abuse or improper treatment.

● There was no effective system to identify, record or respond to complaints. Complaints received from people and relatives were not recorded and therefore could not be evaluated to improve the service. For example, there were no effective systems or processes in place to ensure people's own clothes were routinely returned to them. There was no effective oversight to recognise patterns and themes to complaints. This also meant the outcome for people and other complainants could not be audited to ensure they were addressed effectively.

Systems were not effective to ensure good governance of the service. This placed people at risk of harm. This was a repeated breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were generally pleased with the care and said they would recommend it to others. For example, they said, "I wouldn't go anywhere else. I like it here…", "I've been very fortunate to come here" and "On the whole I like it here but there is room for improvement."

● Visitors said they had "peace of mind" knowing their relatives was happy and safe. For example, they said, "I think it's all very good. The staff are good" and "They genuinely care about my mother…I can go to bed knowing she is cared for."

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

● There were inadequate systems to regularly monitor staff skills and training. The service's processes failed to identify staff had not received appropriate support, training and professional development. There was a failure to create systems to ensure there was regular monitoring of staff skills, including through regular supervision or observation. There were no regular staff meetings, so staff were not provided with a formal time to feedback concerns and ideas.

● An effective admission system was not in place. This meant the management team did not ensure the service could meet the needs of people, particularly those who required assistance to move using equipment or had additional care needs.

● Staff expressed frustration their feedback was not acted upon. Despite concerns from staff regarding an increase in people needing help from 2 staff to move, reviews had not taken place by the provider to ensure people's care needs could be met, particularly in the afternoons.

Systems were not effective to ensure good governance of the service. This placed people at risk of harm. This was a repeated breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

● Staff were loyal to the provider and said they treated them well. The staff team was generally stable with many staff working at the home for a number of years. Staff were positive about working at the home. For example, one staff member said, "It's not like any other home I have worked for… (the provider) get everything for the residents they need…He's not like any other boss I have had… some are in it for the money, but he is in for the residents."
● Relatives told us there was good communication with staff at the home. For example, they said, "I would say the management is listening, open and caring", "Very approachable so far" and "(The provider) is always there, you can ring them even about stupid things…and they listen and will really fight my mum's corner." Relatives said they were kept informed which gave them reassurance and they had an opportunity to feedback their opinions through a yearly survey.

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
● After the inspection, the provider wrote to people living, working and visiting the home to advise they had reconsidered their role as registered manager and were looking to appoint a new person for this role. They said, 'A fresh start will be a positive change for both residents and staff alike, it is time for a new manager who can improve the standard of care that we provide and can be fully dedicated to improving the service as a whole. I will ensure that whoever takes over has the skills and knowledge to strive for excellence and is committed to improving our CQC rating.'
● During the inspection, the provider and their management team worked alongside the inspector to provide requested information. They contacted the local authority's quality assurance and improvement team for advice as they recognised they needed support, and have employed a consultant to help them make improvements.