A.V. Atkinson (Fourways) Ltd

Fourways Residential Home

Inspection report

45 Scotland Hill
Sandhurst
Berkshire
GU47 8JR

Tel: 01252871751
Website: www.atkinsonshomes.co.uk

Date of inspection visit:
24 March 2022
25 March 2022

Date of publication:
20 April 2022

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Fourways Residential Home is a care home without nursing that provides personal care for up to 20 older people, some of whom may be living with dementia. At the time of our inspection there were 18 people living at the service, although one person had recently been admitted to hospital. The care home is in a residential area with accommodation arranged over two floors. There was a communal lounge and a communal dining area on the ground floor. There was a substantial garden at the rear of the building.

People's experience of using this service and what we found
People were not protected against the risk of harm because staff did not always proactively respond when people were identified to be at risk. People were at risk of harm because the service had not effectively managed risks in relation to fire safety, legionella and infection control. The provider did not deploy enough staff to ensure people's needs were met in a timely way to keep them safe. People did not always receive their prescribed medicines at the right time and in the right way to protect them from the risks associate with diabetes. Staff understood their responsibilities to raise concerns about incidents and accidents.

Improvement was required in the decoration of the home to ensure it was suitable for people who experienced living with dementia. People were not always supported to drink enough to protect them from the risks associated with dehydration. People were identified to have needs that exceeded the level of care staff could safely provide. People and relatives had been actively involved developing their care plans and told us the standard of care they received was good. Staff underwent robust selection procedures to ensure they were suitable to work with older people, some who may be living with dementia. The management effectively operated a system which enable staff to develop and maintain the required skills and knowledge to meet people's needs. The manager had arranged for staff to complete enhanced training in March 2022 in relation to pressure area management, moving and positioning people, fire safety and diabetes. People's health was monitored by staff and effectively promoted by a variety of community healthcare professionals.

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

Some people were observed in communal areas looking unkempt wearing soiled clothing until mid-morning, as they had not received their personal care. People told us staff treated them with dignity, respect and felt staff took a genuine interest in their well-being and quality of their life. People and relatives told us they were fully involved in decisions about all aspects of people's care and support.

People were not supported to take part in activities and there was a lack of stimulation for them. People's care was task based and not always person-centred. Staff ensured people received information in formats they could understand. People were supported to maintain relationships that mattered to them. People and

relatives had confidence that the deputy manager would take appropriate action if they raised concerns. People's end of life wishes had been sensitively explored.

Quality assurance processes had not always effectively identified emerging risks to people and ensured they were managed safely. The deputy manager was frequently used to cover staff absence delivering care, which significantly reduced the time available to focus on quality assurance and management of the service. Staff were concerned that the provider did not always listen to their concerns. Staff were to held account about their performance when required, but managers did so in a manner which encouraged them to learn and improve. The managers were committed to implementing reflective practice and learning to drive service improvement.

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, with no breaches of regulation (report published 30 November 2022).

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

The inspection was prompted in part due to concerns received about unsafe staffing levels, poor moving and positioning practice, including people being roughly handled, and people not being treated with dignity and respect. A decision was made for us to inspect and examine those risks. We found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well-led sections of this report.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified six breaches of regulations in relation to safe care and treatment, staffing deployed, safe management of medicines, infection prevention and control, premises not being adapted and decorated to meet people's needs, failure to mitigate the risk of dehydration, the needs of people exceeding the level of care the service could safely deliver, failure to support people to take part in stimulating activities and failure ensure compliance with regulations.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Fourways Residential Home

Detailed findings

Background to this inspection

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

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

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

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.

At the time of our inspection there was not a registered manager in post. There was an interim manager (manager) in place at the time of our inspection. Records demonstrated the manager had begun the process to become the registered manager of the service. The service was managed day to day during the week by the deputy manager, supported on two different weekdays by the nominated individual and the interim manager respectively. The nominated individual is responsible for supervising the management of

the service on behalf of the provider. The nominated individual was also the provider's assistant director.

Notice of inspection
This inspection took place over two days. The first day of inspection was unannounced, whilst the second day was announced.

What we did before the inspection
We reviewed information we already held and had received about the service since the time of the last inspection. We sought feedback from the local authority, safeguarding team and other professionals who work with the service. We checked information held by the fire and rescue service, Companies House, the Food Standards Agency and the Information Commissioner's Office. We checked for any online reviews and relevant social media, and we looked at the content of the provider's website. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
The unannounced site visit on 24 March 2022 commenced at 06.00 a.m. The inspection continued with an announced visit commencing at 07.30 a.m. on 25 March 2022. During the inspection we observed people's care and staff interaction with them during medicine administration and service of meals. We spoke with the nominated individual, the manager, the deputy manager, the chef, assistant chef, eight care staff and a cleaner.

We spoke with three visiting health and social care professionals, including a community nursing sister, a community continence assessor and two mental health professionals. We also spoke with a local authority safeguarding team member.

We reviewed a range of records. This included multiple people's care records, five staff personnel files and all medicines administration records. A variety of records relating to the management of the service, including policies and procedures were also reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We requested and received quality assurance documents and premises and equipment records. We contacted the service to ask further questions for outstanding matters.

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 good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse; assessing risk, safety monitoring and management

- We raised a safeguarding referral with the local authority during the inspection, because there was a delay in seeking medical attention for one person. We informed the deputy manager and nominated individual why we made the referral.
- People were not always protected against the risk of harm. Staff did not always proactively respond when people were identified to be at risk.
- During the site visit, we observed a person who was unwell. They showed signs of distress and pain, which staff were aware of. However, staff did not immediately seek medical advice or react to the person's condition in an effective way.
- One of the inspectors (a registered nurse), completed an assessment of the person's health. They advised the staff that medical attention was required promptly, as the person had developed an infection. When asked, staff had not communicated the person's decline in condition in an effective way, causing a delay in seeking assistance.
- Staff did not take the person's observations until the inspector directed them to. The inspector provided prompting to staff to call the GP or 111 and advise of the infection. The inspector later spoke with the GP, and antibiotics were prescribed.
- Staff did not understand the significance of the infection and the risk of sepsis had intervention not been provided. This placed the person at high risk of harm from an untreated condition.
- The person's legs and feet were also grossly swollen. Staff had failed to recognise this was a side effect of one of their medicines. The inspector also advised the GP of this, and they ordered tablets to treat the fluid in the person's legs. The GP practice nurse reviewed the person during a subsequent visit.
- In January 2022, one person developed a pressure area on their heel. A safeguarding investigation identified that staff did not respond proactively to this risk. As a result, the manager at the time completed a group supervision during a team meeting and arranged for staff to complete training in relation to preventing skin damage on 2 March 2022. This person was meant to have a cushion placed under their foot to relieve pressure and prevent their skin becoming damaged. However, we observed staff brought this person into the communal lounge and moved them into an armchair. The person was only wearing socks and his feet were on the floor, without a supporting cushion. This placed the person at risk of skin damage. We reviewed handover records for this person, which did not identify their risk of developing skin damage. Regular staff were aware of the risk and action required to prevent this. Since our site visit district nurses have confirmed the person's heel has healed successfully.
- Two people living with dementia frequently walked about the home without any allocated support. They were observed to pick up random objects and sometimes inappropriately interact with other people. Their cognition meant they were at increased risk of harming themselves or others, but staff were not observed to

frequently check their whereabouts or actions.
● We noted objects on a ledge that were easily accessible to them and could have posed a risk to their health; this included alcohol hand gel, hand cream and a spice container.

People were at risk of harm from risks that were not effectively assessed and mitigated. This was a breach of Regulation 12 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We checked the safety of premises and equipment. People and others were at risk of harm from risks that were not satisfactorily managed.
● There was a fire risk assessment in place and the fire service had visited to check compliance with fire regulations. However, contingency plans had not been prepared for staff to use in the event of an emergency.
● Evacuation plans for people were either not in the correct place or had not been created. In an emergency the folder would not have provided a reliable source of information for the fire service.
● The business continuity plan and emergency telephone numbers in the same location contained out of date information and references.
● Fire drills were completed, but there were long gaps in the frequency between them. Records showed that during a nighttime fire drill took staff longer than expected to find the source of a mock fire. The record stated staff should practice the drill more often, especially as a nighttime simulation. This had not occurred.
● In another instance, the fire alarm was sounded during the day to check that staff assembled at the entrance promptly, as required. It was recorded that two staff did not present themselves and therefore had not reacted appropriately, in accordance with the provider's fire safety policy. This meant the provider could not be assured that all staff would take the required action to keep people safe during a real emergency.
● There was no risk assessment in place by an accredited contractor for the prevention and control of legionella. Legionella presents a common risk to older adults of causing a severe respiratory illness. A water sample from February 2022 showed a high level of legionella in the water system. The service had flushed and descaled all taps, but this was not the correct action to control legionella growth in the pipework and storage tanks. This placed people at risk of developing an illness.
● A chair in the conservatory was removed once we pointed it out to the management team. It was not fit for people to use and presented an infection control risk.

People were not always protected from building and equipment risks. This was a breach of Regulation 12 (1) (2) (b) (d) (e) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had completed safeguarding training and understood how to report concerns both internally and to other external agencies when required. One staff member told us, "I would intervene first to stop any abuse then report it to [deputy manager] and if they didn't do anything about it I would tell you [CQC].

Staffing
● There were insufficient staff deployed to ensure people's needs were always met in a timely and safe way.
● During both days of our inspection the two nighttime care workers were agency staff. Neither of these staff were qualified to administer medicines. This necessitated the deputy manager and medicine administrator to come in early and finish late to complete morning and bedtime medicines respectively. This meant there was no provision to administer as required medicines during the night, for example, pain relief medicines.
● People and relatives consistently told us there were not enough staff. For example, one person told us, "Staff get tired, but they don't say, they never moan. In the evening meds [medicines] have to be given. There are only two staff on at night and there is no-one trained up to do medicines so sometimes they [medicines administrators] have to stay late. At the moment they stay late quite a few evenings. They

[medicines administrators] should go at 8.00 pm but don't go until 9.00pm, that is a 13 hour day." A relative told us, "Staff are very pleasant, very caring but they could do with more staff. I was there last week and there was a fire demonstration [drill] and staff involved. I rang the bell, no one came for 20 minutes, [person] could have been on the floor, someone should have answered." A relative told us, "[Person] has to wait for a shower and has to wait for 45 minutes or does not get it until the next day, down to being short staffed."

● Call bells were not always accessible to people. In bedrooms, we observed they were sometimes not within reach or there was not one present. In communal areas, people sat together but no call bell was available to them when staff were supporting people elsewhere in the building.

● Call bells often rang for longer than five minutes, particularly in the morning when staff were completing people's personal care in their bedrooms. There were delays to answering people's requests for assistance. Staff did not operate the call bell system effectively, for example it appeared staff were in rooms when they were not there.

● No call bell audits were completed. The service had access to an electronic system that logged call bell response times. No analysis was completed to help determine the correct number of staff to deploy on shifts.

● Staff were observed to be rushed and hurried. On observation, they often walked past people seated who were calling out to them or asking for something. For example, one person repeatedly asked for a tissue and was given one half an hour later.

● Some people were in the lounge room at midmorning who had not received their personal care. They were still dressed in their nightwear, some of which was stained or dirty.

● Staff consistently expressed concerns about the time pressures placed upon them. They stated they had to work long hours and extra hours to make up for staff shortages. Although the service was using agency care workers, the small number of staff meant there were insufficient resources to cover planned and unplanned absences, training for example.

● Without exception, staff told us they needed additional staff in the morning particularly to support people's personal care in a timely fashion. One staff member told us, "Since your [CQC] last visit the number of residents has gone up but the number of staff has gone down. We [staff] are always rushed."

● Minutes of staff meetings in January and March 2022 recorded concerns of staff regarding the risks of insufficient staffing, particularly on the weekend when only two staff were available to support people, whilst one staff member completed medicine administration.

● On the first day of inspection one of the care staff was covering for the absence of the chef. A cleaner was also absent and their hours were not backfilled. This meant the usual cleaning they performed on weekends was not completed.

● Two people who were living with dementia walked around the home independently. We observed staff paid no or little attention to what they were doing. One person interfered with items around the building and had a verbal altercation with another person. Staff were not visually present in the area at times to ensure people's safety.

● A cleaning sign was placed in the loungeroom doorway. People tried to exit the room, and one person moved the sign themselves. These circumstances presented a falls risk had the person not removed the sign for other people to exit and enter.

Insufficient staff were deployed which placed people at risk of harm and delayed care. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment

● Staff recruitment procedures were robust. Staff had undergone relevant pre-employment checks as part of their recruitment, which were documented in their records. These included references to evidence the applicants' conduct in their previous employment, exploration of any gaps in their employment histories

and a Disclosure and Barring Service (DBS) check. The DBS supports employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Using medicines safely

● Medicines were not always safely managed.
● Although people received their medicines, these were not always in a timely way.
● The morning medicines administration ranged from two to three hours. Only one staff member administered the medicines, meaning people experienced delays in receiving them.
● One person with diabetes had their medicine given at the wrong time. The medicine was meant to be administered with their meal but was given nearly an hour later. This placed them at risk of low blood sugar levels and also meant the medicine may not work as expected. A low blood sugar level can be dangerous and cause significant harm if it is not treated quickly.
● Three people needed repeated reassurance and encouragement to take their medicines. One person held their tablets in their hand and would not take them or give them back. The inspection team assisted staff to encourage the person to take the medicines.
● Staff had not considered the use of covert administration of these people's medicines. This is when medicine is hidden in food or fluid to help ensure the person receives it as prescribed. Instead, staff simply recorded the person did not take their medicine.
● There were some missed signatures on the medicines records. These were not detected by staff and it was unclear whether they were administered.
● There were no body maps to show staff where to apply prescribed creams and lotions. The records did not reflect where and how much topical medicines were applied to the person.
● Some information to ensure safe medicines administration was omitted. One person did not have a photo on their medicines profile sheet, others had no record of whether they had swallowing difficulties.
● Pain relief medicine was offered, but the people's pain was not recorded to indicate why the medicine was given. Staff had written "general pain", which provided no information about the type of pain to inform further decisions as to whether other treatment was required.
● Where 'as required' and other medicines were not administered, staff did not always record on the reverse side of the record why they were not given.
● One staff member did not practice effective techniques for recording medicines people took. They gave all of the medicines for each person and then signed all of the records afterwards. Records should be signed after each person has taken their medicines.

People were at risk from unsafe medicines administration. This was a breach of Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The ordering, storage and disposal of medicines was satisfactory. Access to medicines was restricted and they were appropriately locked away.
● Temperature monitoring of the medicines refrigerator was correctly completed.
● The deputy manager was observed to follow best practice techniques when they completed the medicines round.

Preventing and controlling infection

● People were not always protected from the risks of infection.
● The use of personal protective equipment (PPE) was not satisfactory. Staff were observed to wear disposable masks throughout the shift. However, the use of gloves and aprons was inconsistent and not in line with requirements to prevent cross infection.

● Staff were observed to store and remove PPE from their tunic pockets. This meant the items may not be clean, and were carried between different people and areas of the building. PPE should be stored in a dispenser, on a shelf or other appropriate place and collected as needed.
● Disposable aprons were hung on a handrail. We saw they fell on the floor. Several staff walked past without picking them up. One staff member who picked them up placed them back on the handrail for use. As the apron had become contaminated it should have been disposed of.
● Staff did not always disinfect their hands, after touching people or their items, without always performing hand hygiene. This increased the risk of cross contamination, placing people at risk of acquiring an infection.
● Cleaners were observed using the same cloth, mophead and mop bucket to clean all areas of the building. A nationally recognised colour coding system was not used to separate clothes and mops for different areas, for example bathrooms, bedrooms and communal spaces.
● Some PPE was stored outside due to the lack of storage inside the building. However, the provider was unable to ensure that the storage area was designed to ensure it met requirements set out by the NHS. We also observed cleaners who did not remove gloves and disinfect their hands after cleaning, before opening the door and bringing new PPE stock inside.
● Some areas in bathrooms were dusty and not well-cleaned. Pipework was not closed in, and cleaning of the areas around them was problematic leading to accumulation of dust. Objects placed in the way of cleaners, for example items in the bathtub, meant they were not able to clean them effectively.

People were at risk from infections. This was a breach of Regulation 12 (1) (2) (h) () of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were somewhat assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider's infection prevention and control policy was up to date.
● Visiting was in line with government guidance in place at the time.

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

Learning lessons when things go wrong
● Staff were able to demonstrate their understanding of their responsibilities to raise concerns, to record safety incidents and near misses, and to report them internally and externally, where appropriate.
● People, staff and other stakeholders were involved in reviews and investigations
when things went wrong. Staff consistently told us the deputy manager encouraged staff to be open and honest when accidents and incidents happened, so necessary learning could be identified to improve the quality of the service.
● The deputy manager and nominated individual were frequently delivering care which diluted their capability to ensure that that lessons learnt had become embedded and sustained.

Requires Improvement

Is the service effective?

Our findings

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

At our 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.

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

- Improvement was required in the decoration of the premises to ensure it was suitable for people living with dementia..
- Many people had a form of dementia, requiring careful consideration of the surrounding environment. Some areas of the building were not decorated or adapted in accordance with best practice. For example, the use of colours, patterns, lighting and textures was not considered to ensure they promoted people's safety and well-being.
- The service had not completed an assessment, audit or used another recognised tool to determine the best practice aspects to use in the decoration and adaptation of the premises.
- In some areas, wall paint was tired or dirty. We were told that repainting was scheduled but no fixed date was provided. Some bathrooms required renovation to bring them to an acceptable standard of space and accessibility.
- A corridor which had been previously decorated as a 'nature walk' was not maintained, and people weren't encouraged to use the area. Instead they sat in groups in a small enclosed lounge room.
- The single stairway between the ground and first floor was not safe for use by people with mobility issues. There was a steep step at the top where a makeshift ramp was installed. Gates at the top and bottom provided visual cues to prevent people entering the stairwell; only a simple sliding bolt prevented the gates form being opened and there was the risk they would be opened exposing people to the risk of falling.
- Storage was lacking. In a staff toilet, mattresses and other equipment were stacked on the floor. In a cupboard with a water pump and heating equipment inside, people's clothes and shoes were stored. Personal protective equipment stations were not situated throughout the building, and staff had used inappropriate areas to store items. For example, disposable gowns were placed into a bathtub.
- The radiators in the conservatory and dining room were not switched on in the mornings. People kept saying they were cold to one another. Staff took no action in relation to this. When we discovered this, we reported it to the management team. The radiators in this area were switched on during a warm part of the day and made the area very warm. People then expressed feeling uncomfortably hot. Routine monitoring and recording of room temperatures had not occurred.

The premises were not sufficiently decorated and adapted to meet everyone's needs. This was a breach of Regulation 15 (1) (a) (b) (c) (d) (e)(f) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● People were not always asked about their food and drink preferences and provided with choice.
● In the morning staff handover, care workers were allocated to complete the morning tea and afternoon tea. This approach was task-focused and there was no discussion about food and fluid throughout the remainder of the shift, for example what was for lunch and what choices were available.
● We observed staff provide morning tea. People were given half an unpeeled banana and a satsuma. They weren't asked if this is what they wanted, and some people could not peel the banana. Staff failed to recognise when people could not peel the fruit.
● We observed two occasions where fluids were thickened by staff incorrectly. Fluid thickeners are powders added to change the texture of a drink and prevent choking. Staff had not followed the directions for the product and the drinks were not of the correct thickness.
● Tea, coffee and squash were provided during the drinks 'rounds'. Although jugs of fluid were in the small lounge, people were not routinely offered and encouraged to take fluids. There was a risk of dehydration, especially for people who were not able to express their thirst.
● Two people who walked about were not offered fluids except during the drinks 'rounds'. One person was observed to drink multiple times on both days from a hand-wash sink. We addressed this with the management team though the person was still observed drinking water from the hand-wash sink. The inspection team offered the two people fluids during the site visit. They drank several cups of fluid when we encouraged them to.
● There was a 'hydration station' sign on a table in the conservatory, however there were no drinks and cups there for people who walked about to help themselves to fluids.

People were not offered enough fluids to prevent dehydration. This was a breach of Regulation 14 (1) (2) (a) 4 (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Lunch people received was nutritious and healthy. People appeared to enjoy their meal. There were some delays with people who required assistance with their meals, however they did eat when staff were available to support them.
● Most people and their relatives told us people enjoyed their meals and looked forward to the chef's visit each morning to find out their choice for lunch. One person told us, "Chef cooks us good meals, he's a lovely man who worked on the liners, we get loads of fruit, even strawberries, grapes, oranges, plums. Plenty of veg, fish and chips today, beef hot pot is lovely, roast dinners are lovely, pork and gammon, some lovely food." However, one person told us, ""Food is not to my liking, it is a bit bland, we [people] get enough variety but the veg is mostly cold, but I don't like to complain."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's care and treatment needs and preferences had not always been assessed by suitably skilled staff.
● Two people were identified as having needs that exceeded the level of care that could safely be provided by the service. One person required a specialist care home with nursing to effectively meet their needs. It was identified that the service had advised the funding authority the person needed a new placement, although this was only after a complaint by another person's family member.
● We spoke with a visiting community mental health professional who agreed the service was not equipped to meet the needs of an individual they had come to assess.

People were at risk of harm because assessments had not always identified the needs of people exceeded the level of care that could be safely delivered by the service. This was a breach of Regulation 12 (1) (2) (a) (b) (c) (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The manager who was a qualified nurse told us they would clinically review all future admissions to

ensure the service could fully meet the person's needs before they were admitted.

Staff support: induction, training, skills and experience

● People and relatives told us they thought staff had the required skills and experience to meet their assessed needs safely. One person who required support to be transferred using a hoist told us, "I came here (conservatory) in the wheelchair today. I always have two staff, have a hoist and I feel safe, I do feel safe always."

● The manager and deputy manager operated a system of training, competency assessments, supervision and appraisals. This enabled staff to develop and maintain the required skills and knowledge to support people according to their needs.

● All staff had completed training in line with core subjects advised by Skills for Care and the care certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors.

● Staff had completed theoretical training in relation to the safe management of medicines. We reviewed the competency assessments for staff who administered medicines and found these were completed regularly and in accordance with the provider's policy. The deputy manager operated a framework of observed spot-checks and one to one supervisions.

● Staff consistently told us their training fully prepared them to meet the needs of people. New staff completed a thorough induction process that equipped them with the necessary skills and confidence to carry out their role effectively. A staff member told us their comprehensive training made them feel confident they were ready and able to meet people's needs.

● In response to recent incidents analysed by the management and guidance received from a local authority quality assurance visit, the provider had arranged for staff to complete further training in relation to pressure area management, moving and positioning people safely, supporting people with diabetes and fire safety.

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

● People's health was monitored and promoted by a variety of community healthcare professionals. Three healthcare professionals visited people during our inspection, and we spoke with them.

● Visiting healthcare professionals told us the managers had made appropriate and timely referrals and had acted swiftly on their recommendations.

● People and relatives told us that staff made prompt referrals to health and social care professionals when required. For example, people had been referred appropriately to dentists and opticians in relation to their visual and oral healthcare needs.

● Following staff learning and training in relation to the management of pressure areas, we found they had worked proactively with healthcare professionals. For example, staff promptly organised for a person to have an air mattress and further equipment, including gel cushions. The managers arranged appropriate and timely referrals to the podiatry and district nursing team. Effective wound care and two hourly repositioning led to a successful outcome. District nurses acknowledged the timely referral and effective implementation of their guidance by staff to be significant contributory factors in relation to the fast healing of these pressure areas.

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, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked the service was working within the principles of the MCA and found that appropriate legal authorisations were in place when needed to deprive a person of their liberty.

● The manager demonstrated a clear understanding of the DoLS process and when applications were required. The manager and deputy manager operated a tracking system to ensure that DoLS authorities were reviewed regularly and did not expire.

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 this key question was not inspected. At our penultimate inspection we rated this key question requires improvement. At this inspection the rating has remained requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence

- The level of staffing had an adverse impact on the support for people's dignity during the mornings.
- Some people were observed in communal areas to be in soiled clothing and their hair was unkempt until the mid-morning, as they had not received their personal care at the time. After personal care, people were neatly dressed and well groomed.
- We observed a relative visit a person and ask whose clothes they were wearing. When we spoke with the relative, they stated it was not their mother's cardigan and removed it, placing it on the seat. Another person picked it up and wore it, but it was not their clothing either.
- Personal care was provided privately, with doors closed. We observed staff knock on bedroom and bathroom doors before entering. People were addressed by their name, using their personal preference.
- People and relatives told us they were treated with dignity and respect. For example, one person told us, "They [staff] are nice girls, everybody is so nice and treat me with respect, they knock on the door always, that is part of their training."

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

- People consistently told us staff treated them with dignity and respect..
- People felt valued by staff who showed genuine interest in their well-being and quality of life. For example, one person told us, "They [staff] always talk to me and take an interest in me, which makes me feel special." Another person told us, "They [staff] are trying to settle me by just being kind to me, I would recommend it, people are so friendly here."
- Despite being rushed at times, staff were observed to be kind and caring with people.
- People received kind and compassionate care from staff who used positive, respectful language which people understood and responded well to. Some care workers were observed to facilitate relaxed, meaningful conversations with people when they wanted to talk about topics of their choice.
- During medicines administration, the deputy manager was pleasant and conversed well with people. People smiled and laughed when the deputy manager greeted them; some people made jokes and the deputy manager encouraged them to be jovial. People were happy to see and interact with the deputy manager, especially those in their bedrooms.
- Staff were mindful of people's sensory perception and processing difficulties. For example, our expert by experience was impressed with the compassionate way staff supported a person using a social media application to share their experience with us. This included sensitive support to use headphones when the person experienced difficulty hearing and providing explanations and clarification when required.

● The deputy manager and staff had built open relationships with people and their families, who were made to feel welcome in the home. There was a positive, cheerful atmosphere in the home, which was consistently noted by people's relatives. One relative told us, "It seems friendly, homely, all the staff are very good, they are really nice people and I would choose it again for [person]."

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

● People could make decisions about all aspects of their care and their choices were respected by staff. Care plans were developed with people, their relatives, where appropriate, relevant professionals and from the staff team knowledge gained from working closely with them.

● People and relatives consistently told us they were fully involved in decisions about all aspects of people's care and support.

● People and relatives told us the reassuring and compassionate nature of the deputy manager and core staff had a positive impact on their mental well-being.

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 this key question was not inspected. At our penultimate inspection we rated this key question requires improvement. At this inspection the rating has remained requires improvement. This meant people's needs were not always met.

Support to follow interests and to take part in activities that are socially and culturally relevant to people.
- People did not always receive personalised care that was responsive to their needs.
- People were not supported to follow their interests and take part in activities that were socially and culturally relevant and appropriate to them.
- There was a lack of social stimulation for people, and they mostly stayed in their bedroom, sat in a small lounge, or walked about.
- There was no activities coordinator employed at the time of the inspection. There was no information on display to inform people of activities, although there were some pictures and photos of historical activities. One person told us, "It was better when we had the arts and crafts lady and now waiting for a new one, not really enough to do, I want animals to come in, I love to see dogs." A relative of a person receiving a period of respite care told us, "It seems okay, the carers [staff] are all kind and friendly, but there doesn't seem to be much for people to do."
- As staff were busy, there was a lack of interaction between personal care and mealtimes. Some people tried to talk to each other, but not everyone was able to communicate verbally in a meaningful way.
- Staff told us they wished they had more time to engage in meaningful activities with people but were always busy being task driven.
- On the two days of the inspection, the weather was suitable for people to go into the garden. However, despite the garden being a closed area, the doors were kept closed and no one was asked if they would like to go into the garden. One person told us, "Got a lovely pergola, lovely garden, we will hopefully get out when it is really warm, got a minibus and used to go into Windsor and take sandwiches and feed the ducks."
- There was no evidence of recent outings into the community. People were not encouraged to follow their interests or social pastimes.
- Staff resorted to playing music on repeat in the lounge room. We noted two people sing along, but none of the staff participated as they were not in the area. The music was the same on both days. One person we spoke with said she loved knitting and was working on a garment.

People were not supported to follow their interests and take part in activities that were socially and culturally relevant and appropriate to them. This was a breach of Regulation 9 (1)(a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
- Care was not always person-centred. Some care staff were focused on what tasks they needed to support people with, rather than the person's needs or preferences.

● Staff placed morning and afternoon tea in front of people in the lounge. They were not asked what they wanted to eat or drink or if they wanted anything different. One person was provided fruit, tea and biscuits but consumed none of it. It was removed and the person was not asked if they would like an alternative.
● There was no suitable room for staff to take their breaks in. Instead, they ate and drank in the communal dining room. However, none of the staff sat with people when they had their main meals. They did not attempt a meaningful interaction with people during mealtimes when the opportunity was present.
● Sometimes staff spoke in their first language with one another in front of people, which undermined their relationships with people. For example one person told us, "We [people] have the language barrier, sometimes I don't understand what they [staff] are saying, most do speak English, but they [staff] always speak their language to each other, be nice if they speak in English, they all seem very happy."
● Staff were overheard in various areas of the service to state what tasks were required without a person-centred demeanour. For example, one staff member stated they would do the 'tea round' and the other would do the 'laundry round'. Others said a person or people needed bathing or changing whilst walking down hallways.

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 ensured people received information in a way they could understand and process, allowing for disability or impairment, such as poor eyesight or hearing.
● Information was provided in formats to meet people's individual needs. Pictures had been used to provide information historically, such as menus and activities, to make this more accessible for people.

Supporting people to develop and maintain relationships to avoid social isolation;
● Staff effectively supported people to maintain relationships that matter to them, such as family, community and other social links. People's relatives and friends told us they were made to feel welcome by friendly staff and were able to visit when they wanted, without being unnecessarily restricted.

Improving care quality in response to complaints or concerns
● The service had an appropriate, inclusive complaints policy and procedure, as well as information which was provided to people and their relatives when they moved in.
● People and families felt able to make complaints if they wished. People and their relatives knew the deputy manager and senior staff by name and saw them regularly. People and relatives knew what to do and who they would talk to if they had any concerns.
● There had been several complaints since the last inspection, which had been dealt with in accordance with the provider's policy and procedure. The deputy manager had used the learning from concerns as an opportunity to drive improvements.
● People and their relatives were given the opportunity to give their feedback on the service during care reviews and residents meetings.

End of life care and support
● No people were receiving end of life care at the time of inspection.
● People's end of life wishes were sensitively considered and their plans explained what was important to them, things they wanted to avoid, and where they wanted to be cared for.

- Some people told staff they did not wish to discuss their end of life wishes, which staff respected.
- Staff consistently told us they were supported by the service with empathy and understanding when people passed away.

Requires Improvement

Is the service well-led?

Our findings

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

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

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

- Governance and performance management was not always reliable and effective. Quality assurance processes had not always effectively identified emerging risks to people and ensured they were managed safely.
- The provider's processes had failed to identify breaches of regulation found during this inspection.
- The provider's systems and processes had not enabled the registered person to identify where quality and safety were being compromised and to respond appropriately and without delay.
- The registered person had not always identified risks and introduced measures to remove the risks in a timely manner that reflected the level of risk and impact on people using the service. For example, risks to the health, safety and welfare of people had not been appropriately escalated to relevant healthcare professionals.
- The deputy manager was knowledgeable, skilled and experienced in overseeing shifts and taking responsibility.
- However, the deputy manager was used to fill rota shortages and was expected to work long days, including weekends, in the absence of other care workers.
- They were professional in their approach, but time they could have spent on quality projects and governance of the service was taken away by the number of hours they were required to complete to support people with their personal care.
- Some audits were completed, for example on medicines and about infection prevention and control. Where a deficit was found or an improvement was required, it was not recorded in an appropriate action plan.
- On night shifts, there were two care workers deployed. Two nights in a row, these were both agency workers who were not authorised to administer medicines. The provider had not considered people may experience pain during this period, and therefore would not have access to pain relief in a timely way.

The registered person failed to fulfil the legal requirements of their role, to ensure compliance with regulations, to assess, monitor and improve the service to ensure that quality and safety were not compromised and to mitigate risks to people was a breach of Regulation 17 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

● Staff felt respected, supported and valued by the deputy manager. Staff felt able to raise concerns with deputy manager and manager. However, staff were concerned that the provider did not always listen to their concerns. For example, concerns raised in team meetings regarding unsafe staffing levels had not been acted upon.
● People, relatives and professionals described the deputy manager to be conscientious and committed to the people living in their home, who led by example and provided a good role model for staff.
● People, relatives and staff consistently told us the deputy manager was highly visible in the service, very approachable and took a genuine interest in what people, staff, family, advocates and other professionals had to say.
● People and relatives praised the deputy manager but they were concerned about the destabilising effect caused by the high turnover of managers. For example, one person told us, "[Deputy Manager] is very nice but going soon, been about nine managers, the stress gets to them. The area manager [nominated individual] used to be a manager here too, he is nice and he chats." A relative told us, "Previous management did pretty well, when they left things went downhill. The area manager is good at communicating but there are endemic problems with Head Office [provider] and communication, Head Office [provider] is not quick enough getting information out like the manager had left and the home did not have a manager from September to December."
● The deputy manager and nominated individual worked directly with people and worked hard to instil a culture of care in which staff truly valued and promoted people's quality of care. For example, one person told us, "[Deputy Manager] is very nice, seems to work jolly hard, they are lovely staff."
● Minutes of staff meetings demonstrated the deputy manager and manager were alert to the culture within the service and spent time with staff and people discussing behaviours and values.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider's policy identified the actions the manager and staff must take, in situations where the duty of candour applied. The manager and deputy manager assumed full responsibility when concerns had been raised or mistakes had been made.
● The manager understood their responsibilities to inform people, or their representative, when things went wrong, and the importance of conducting honest and transparent investigations to identify essential lessons to prevent further occurrences.
● Where concerns had been raised or accidents and incidents had occurred, the management team had completed thorough investigations and spoke directly to people to explain the circumstances, action they had taken and apologise.
● The management team took an open and honest approach to work with people and their families. Relatives praised the management team for being open and honest whenever they had raised concerns.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People, and those important to them, worked with managers and staff to develop and improve the service. For example, one person told us, "[Deputy manager and chef] always come to see me and ask what they can do better."
● The staff meeting minutes contained evidence that staff were asked for opinions, ideas or suggestions and were not constrained by the management agenda
● Surveys of people, relatives and staff had not occurred since the last inspection. There was a plan to conduct them and gather feedback.

Continuous learning and improving care

● Quality assurance arrangements were not always applied consistently. For example, required improvements had not always been identified or action to introduce improvements.
● Staff meeting minutes demonstrated the deputy manager and manager were committed to implementing reflective practice and learning to drive service improvement.
● Staff told us the deputy manager held them to account about their performance when required but did so in a manner which encouraged them to learn and improve.

Working in partnership with others
● The nominated individual and manager demonstrated their engagement in local and national quality improvement activities.
● The deputy manager had engaged in local forums to work with other organisations to improve care and support for people living in the home.
● The service was transparent and collaborative with all relevant external stakeholders and agencies. For example, the deputy manager had embraced and welcomed the advice and guidance from the local authority quality assurance team.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not supported to follow their interests and take part in activities that were socially and culturally relevant and appropriate to them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were at risk of harm from risks that were not effectively assessed and mitigated. People were at risk of harm because assessments had not always identified the needs of people exceeded the level of care that could be safely delivered by the service. People were not always protected from building and equipment risks. People were at risk from unsafe medicines administration. People were at risk from infections.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People were not offered enough fluids to prevent dehydration.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premises were not sufficiently decorated and adapted to meet everyone's needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person's failure to fulfil the legal requirements of their role, to ensure compliance with regulations, to assess, monitor and improve the service to ensure that quality and safety were not compromised and to mitigate risks to people was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Insufficient staff were deployed which placed people at risk of harm and delayed care. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.