Four Seasons (Evedale) Limited

Charnwood

Inspection report

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Ratings

Overall rating for this service	Inadequate

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?	**Inadequate**

Summary of findings

Overall summary

About the service: Charnwood is a care home with nursing. The care home is registered to accommodate up to 88 older people, in two separate adapted buildings. Charnwood House provided mostly nursing care to people living with dementia and some residential care. Charnwood Court provided general nursing, residential and palliative care. At the time of our inspection 21 people lived in Charnwood House and 25 people lived in Charnwood Court.

People's experience of using this service:
At this inspection we found the provider was no longer in breach of Regulation 9 of the Care Quality Commission (Registration) Regulations 2009. This was because some improvements had been made in this area. However, we found the provider had not made sufficient improvements in other areas since our last inspection and we found a continued breach of Regulation 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

People were not protected against the risk of infection. Urine stained mattresses had not been replaced and procedures to safely store used needles and razors that posed a risk of infection had not been followed. Staff did not follow hand washing guidance or wear gloves when administering eye drops.

Medicines management procedures did not always follow recognised good practice procedures. Some items in the medicines clinic rooms such as dressings for wounds, were out of date and not all equipment had been left on charge as expected.

Some people's care plans did not reflect their current needs or health conditions. Some staff did not use safe and appropriate moving and handling techniques with people or offer reassurance and communication when people were moved with such equipment as hoists.

Staffing had not been planned to ensure people received timely care. For example, over lunchtimes when we observed some people waited for up to 20 minutes before staff were able to assist them with their meals.

Systems and processes had not always been operated effectively to assess, monitor and mitigate risks and ensure improvements. Actions had not always been taken to improve the quality and safety of the service when shortfalls had been identified. Not all personal confidential information was kept securely. Statutory notifications had not always been sent in a timely manner as required.

People were happy with their meal choices, however not all people had positive outcomes from their dining experiences as they sometimes had to wait for up to 20 minutes for staff to assist them with their meals.

People's health and care needs were assessed with nationally recognised assessment tools, however

photographs had not been effectively used to monitor wounds.

Some actions had been taken to adapt the premises to people's needs, however sometimes the noise levels from televisions and radios all on at the same time did not always create a calm atmosphere for people.

We observed some staff were caring and took time with people, however this was not consistent. For example, we saw some staff did not engage with people when they had the chance too.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. People and relatives had been involved in their care plan and decisions about their care. People's privacy and dignity was respected and staff promoted people's independence.

People were able to complain and any concerns raised were investigated. People's views and those of their relatives had been gathered. Care plans were in place for when people required care at the end of their lives.

Staff were knowledgeable in areas relevant to people's needs, including understanding dementia. The provider followed recruitment processes to help them recruit staff that were suitable to work at the service.

Rating at last inspection:
At our previous inspection, the service was rated as 'Inadequate.' (Published 19 February 2019).

At the previous inspection we found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We placed the service in 'special measures.' We expect services placed in special measures to have made significant improvements at their next inspection.

The overall rating for this service remains 'Inadequate' therefore the service remains 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.

Why we inspected:
This is a scheduled inspection to check on the improvements made since the service was placed in 'special measures' at the previous inspection. The inspection also considered concerns received about a serious injury. This incident is subject to a criminal investigation. As a result, this inspection did not examine the circumstances of the incident.

The information CQC received about the incident indicated concerns about the management of mealtimes and wound care. This inspection examined those risks.

Following the previous inspection the provider submitted an action plan to tell us what actions they would

take to become compliant with the other regulations.

Follow up:
We will continue to review information we receive about the service until the next scheduled inspection. If we receive any information of concern, we may inspect sooner than scheduled.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our Safe findings below.	**Inadequate**
Is the service effective? The service was not always effective Details are in our Effective findings below.	**Requires Improvement**
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**

Charnwood

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection team included two inspectors, two specialist professional advisors whose area of specialism was in nursing and two 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. Their area of expertise was in the care of older people and the care of people living with dementia.

Service and service type:
This service is a 'care home with nursing'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a registered manager in place. A registered manager is, along with the provider, legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
This inspection was unannounced.

What we did:
Before the inspection we looked at the information we held about the service, this included whether any statutory notifications had been submitted. Notifications are changes, events or incidents that providers must tell us about.

We checked whether Healthwatch Nottinghamshire had received feedback on the service; they had not. Healthwatch Nottinghamshire is an independent organisation that represents people using health and

social care services.

Not everyone could give us their views on the care they received at the service. We therefore used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

The provider completed a Provider Information Return. This is information we require providers to send us to give us some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection we spoke with five people and five relatives about the service. We also spoke with the registered manager, a resident experience support manager, resident experience care specialist and a member of the provider's care improvement team who specialised in dementia care. We spoke with two nurses, five care staff, two activities staff, two domestic staff and one chef.

We looked at the relevant sections of eight people's care plans and reviewed other records relating to the care people received and how the service was managed. This included risk assessments, quality assurance checks, accident and incident reports, staff training and policies and procedures.

We reviewed information sent to us from the local authority commissioners. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority or by a health clinical commissioning group. They had completed an audit on the service in November 2018 and March 2019. They had made recommendations for the service to improve.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same, 'Inadequate'.

People were not safe and were at risk of avoidable harm. Some regulations were not met.

At our previous inspection in November 2018, we found a breach of Regulation 12 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because risks were not always managed safely, there was not always enough staff and medicines and medical equipment had not always been managed safely. At this inspection we found some improvements had been made, and further improvements were still required.

Preventing and controlling infection

●At our last inspection we identified not all equipment was clean and some parts of the premises could not be effectively cleaned.

●At this inspection, we found equipment was clean, however not all steps had been taken to ensure effective infection prevention and control. For example, we checked one person's pressure relieving mattress and found this to be heavily stained and strongly smelling of urine. We checked a pressure relieving cushion and found that this was also stained.

●We observed a staff member administered eye drops to a person without washing their hands prior to administration, or wear gloves. This did not protect the person from risk of infection.

● A sharps bin with two disposable razors left inside had no lid on. Sharps bins are designed to safely collect 'sharps' such as razors and needles. The sharps bin had not been dated and signed to confirm when it was assembled.

●We found a cleaning product in the clinic room when this should have been safely stored in the COSHH (control of substances hazardous to health) cupboard.

Using medicines safely

● At our previous inspection we found medicines were not always being managed safely. At this inspection we found improvements had been made to the administration records of medicines and emergency grab bags. However, we found medicines for disposal were not always stored securely and equipment to be used should a person's health decline had not been left on charge.

●We found medicines disposal bins overfull with medicines, without lids securely in place and without identification tags on.

●We found some wound care dressings and a sanitising hand gel in one of the clinic rooms had passed their expiry dates.

●We found medical equipment in one clinic room was not fully charged nor had it been left on charge. This equipment had been used the previous week. We made staff aware and they then put this equipment on charge. We were concerned as we had also found this equipment not on charge at our previous inspection.

●Staff were not always free from distraction when administering medicines. This can create more potential for errors being made.

Assessing risk, safety monitoring and management

● At our last inspection we found risks associated with people's care needs, such as from falls, choking and behaviours that challenged were not always identified and actions taken to mitigate those risks. Risks to staff had not always been reduced. At this inspection we found the provider had made some improvements. The provider was in the process of re-writing care plans and risk assessments. Where this had been completed we found care plans and risk assessments were accurate and up to date.

●However, the registered manager told us there were approximately twenty people's care plans and risk assessments that still required updating. Where these had not yet been updated people were at risk of inconsistent care as staff did not have up to date information on their health conditions. For example, we reviewed the care records for one person who the registered manager told us still required their care plans and risk assessments to be updated. They had diabetes and epilepsy and on day one of our inspection there was nothing in this person's care records to tell staff about these health care needs. This had been put in place on day two of our inspection and we saw the senior staff member update care staff on these new care plans. We were concerned this information had not previously been contained in a care plan to ensure staff understood the person's needs and could provide consistent care.

●We found staff did not always assist people to mobilise safely in wheelchairs. One person described how staff supported them in the hoist. They said, "Staff were kind and gentle when I first came in, but it feels they are rougher now."

● The reassurance and explanations staff gave to people when they were using lifting equipment such as hoists was variable. We saw some staff did communicate, explain and reassure people when this took place. However, at other times we saw minimal reassurance and explanation.

●People did not always receive consistent care from all staff. We saw most, but not yet all staff consistently followed care plan guidance for when people showed behaviours that challenged. For example, the care plan for one person stated staff should use diversion techniques and distraction if they became confused and distressed. We saw this was successfully employed by one member of staff, but not consistently by others.

This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Other aspects of safe medicines management were seen to be in place. This included medicines stored securely and at the correct temperature. Guidelines were in place to guide staff when to administer medicines 'as and when required' rather than at set prescribed times. Staff had recorded any medicines administration accurately on medicines administration charts. We saw staff checked whether people required any pain relief.

●Where people had behaviours that could sometimes place themselves or others at risk of harm, the provider had taken steps to seek to understand this and to create ways of reducing risks in a personalised way. For example, one person was supported to visit another location each day as this represented a previous routine for them. Staff told us this helped the person remain calm and we saw the person enjoyed this. Staff told us they felt people living with behaviours that could present harm to themselves or others were well-managed. Although there were still some incidents reported of where staff had received injury from people records showed these had been reviewed by the provider's dementia care team and actions taken to reduce future recurrence.

Staffing and recruitment

● At our last inspection there were not enough staff to meet people's needs and we found a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●At this inspection we found the service did not deploy enough staff at busy times to ensure people received timely care. People and relatives had mixed views on whether there was enough staff and on how quickly staff responded to requests for help.

●One relative told us they were concerned there were not enough staff at busy times such as over mealtimes when people required staff to assist them with their meals. They said, "There are not enough staff. Staff are excellent, some are upset that they can't give enough time to people. At weekends, sometimes there is only one [staff] on this upper floor. The bells are ringing, staff are [assisting a person with their meal] and can't answer the bell and [assist] people at the same time."

●Staff we spoke with told us it was sometimes difficult to provide cover in communal areas if two care staff were assisting people with personal care. Another member of staff told us people sometimes had to wait in the morning if people all wanted to get up at similar times.

●The registered manager told us they used a staffing tool to provide an indication of the number of staff needed. However, this did not show how people's needs had been used to inform staff deployment. For example, how many people required the assistance of staff with their meals or how many people required assistance of two staff members with personal care and mobility. Nor did the registered manager monitor staff response times to nurse call requests. Without this the provider could not show how they had planned staff deployment to meet people's needs in a timely manner and that they checked to ensure people received timely help to nurse call requests. We saw many people required assistance with their meals. Whilst staff provided this care to some people straight away, other people did not always receive prompting to eat their meal in a timely manner. For example, we observed three people sat for 20 minutes with their food in front of them before staff were available to provide assistance. Staffing was not planned to ensure all people received timely care during predictably busier times of the day.

This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Some views on staffing were positive. One relative told us, "We chose here because of the high number of staff. I know [my relative] is supervised. If I need to speak to someone there's always staff here."

●We observed staff maintained a presence in communal areas to and saw they were present to respond to people who may be at risk, for example, from falls.

●Staff were recruited safely, and checks had been completed to ensure they were suitable to work with people. For example, two references were obtained, and suitable checks were made to ensure safe recruitment decisions were made prior to employment.

Systems and processes to safeguard people from the risk of abuse

● Most people told us they felt safe. One person told us, "I feel safe here. The carers are nice people. You feel you can talk to them."

● Staff we spoke with understood when and how to report any potential safeguarding concerns.

Learning lessons when things go wrong

●Incident and accident forms were completed, and these had been used to try and make improvements. For example, staff told us incident reports regarding any behaviours that challenged had been reviewed and used to help update people's care plans and risk assessment.

Requires Improvement

Is the service effective?

Our findings

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same, requires improvement.

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

At our previous inspection we found not all staff had been trained in areas relevant to people's care needs. In addition, not all staff had regular supervision. Supervision provides staff members with the opportunity to reflect and learn from their practice, receive personal support and professional development. This was a breach of Regulation 18 of the Health and Social Care Act 2009 (Regulated Activities) Regulations 2014. At this inspection we found the provider had made improvements to staff training and supervision.

Staff support: induction, training, skills and experience

- Staff told us, and records confirmed they had recently had an opportunity to review their individual work and development needs. All the staff we spoke to felt that they were supported to develop their knowledge and skills. The registered manager planned future supervision dates with staff to ensure staff had regular opportunities to reflect on their practice and professional development needs.
- Records showed staff had completed training in areas such as moving and handling. A schedule of follow up observations on staff skills in moving and handling were also in progress to help ensure staff competency. The registered manager told us staff were trained in safeguarding and infection prevention and control as part of their induction and on e-learning. We found staff were knowledgeable in these areas. However, the provider had also identified 'face to face' safeguarding training was required for staff; we found most staff had not yet completed this. Staff had not yet completed all the training identified by the provider as required for their role.

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

- People's experiences of mealtimes and drinks varied. This was because some people received care from staff straight away with their meals and other people did not receive assistance until 20 minutes after their meals had been served. At another time we observed two people not receive assistance with their drink for 20 minutes. One person's cup of tea had gone cold and had been left with a biscuit floating on the top of it. One relative told us, "We are constantly asking for [staff to assist person with their food] and sometimes there are no drinks.
- People were offered choices with their meals and snacks and drinks were available throughout the day. People requested meal choices other than from the planned menu and their choices were met. One person told us, "Staff bring tea around at about 11am and 3pm. On a Sunday we have a buffet and I like that. If we have pork or hard food, it's not so easy for me to digest so I choose something softer. They have nice puddings."

●Records showed people at risk of weight loss were monitored and people received dietary supplements when required to help prevent weight loss. People at risk of dehydration had their fluid intake monitored. Some people were at risk of poor dietary and fluid intake as staff were not always able to provide timely care at mealtimes.

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

●On day one of our inspection we found the competing noise levels from different televisions and a radio in communal areas had not been well-managed. The noise level meant staff were talking loudly to one another to be able to communicate across the noise. We found one person's care plan also stated they were calmer in quieter environments. On day one we observed people were less settled than on day two when the noise levels from televisions and radios had been more managed.

●A 'quiet lounge' was used routinely for some people in 'The House' to watch television. People told us they used this room as they found the main communal lounges loud. Whilst this meant this group of people could have a quieter environment, it also meant should a person have wanted to have time away from the television, there was no alternative provision other than their bedroom.

● The door to the clinic room was unsafe. This was because the door was not able to be opened from the inside and so there was a risk staff could become locked inside. This was repaired on day one of our inspection however, staff told us it had been like this for some time prior to our inspection.

● Some actions had been taken to adapt the premises to meet people's needs. For example, toilet and bathroom doors were all the same colour. This can help people living with dementia to orientate. Some people had photographs on the outside of their bedrooms to help them identify their own room.

●A lift provided access between floors and there was some signage to help people orientate around the building. However, this was not consistently helpful. For example, a staff office had a picture of a comfy chair and was labelled 'lounge.' The adaption and design of the service did not always meet people's needs.

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

●People's care needs and associated health care risks were assessed with nationally recognised assessment tools and regularly reviewed.

●Records showed wounds related to pressure ulcers were recorded and monitored. However, photographs to record the wound and monitor any improvement or deterioration had not been kept up to date or were absent from two of the care plans we reviewed. This meant monitoring was not as effective as it could have been.

●Assessments considered people's equality and diversity needs, such as religion. These were discussed and considered with people on admission and kept under review.

●The provider's policies and procedures referred to best practice guidance and current legislation.

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 Act 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 any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met. The provider had made applications to the local authority when restrictions had been identified.

● The provider demonstrated decisions had been considered in line with the MCA and best interests

decision making. This meant steps had been taken to ensure people's rights were upheld and considered.

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

- People told us they had access to other healthcare services they needed. One person told us, "The doctor comes every Thursday and staff call him out if you are poorly. That happens pretty quickly."
- Records showed where other professionals were involved in people's care to ensure people's health was supported. Staff told us how they monitored people's health needs and obtained relevant advice from other healthcare professionals when required.
- Healthcare professionals were involved in people's care to help ensure good outcomes for them. For example, assessment and guidance had been sought from a range of disciplines including nurse practitioners, speech and language therapists, the falls team, community psychiatric nurse, optician, chiropodist, dentist and the memory clinic. This helped to promote effective healthcare outcomes for people.

Requires Improvement

Is the service caring?

Our findings

This means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now remained the same, requires improvement.

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Ensuring people are well treated and supported; equality and diversity

● People experienced inconsistent levels of interaction and engagement from care staff. We saw staff talk calmly and kindly to people. One person told us, "Staff are helpful, just tell them what you want, and they do it for you." A relative told us, "The staff are so patient, I wonder at their patience with people."

●However, we observed staff varied in how much conversation they had with people. For example, we saw examples of some staff making conversation as they provided care. However, we saw other staff who did not take opportunities to talk with people. For example, we saw one staff member waiting with a hoist next to a person. They were waiting for another staff member to help them use the equipment. They made no conversation, no eye contact or smiles with the person they were waiting with. We saw caring interactions also varied when staff assisted people with their meals. Some staff spoke with people and described their meal; whilst we also observed staff making no conversation during this time.

●People and their relatives both commented on how there was a variation in the caring nature of care, depending on which staff provided it. For example, a person told us, "Staff come, but then they go off again; the old ones stay, but not many. A few staff have been here a long time and know me well." A relative told us, "One member of staff, when she does [my relative's] personal care, she puts music on. I know when that member of staff has been on, [my relative] is more animated." They told us they felt the staff member had developed a close and beneficial relationship with their relative and they did not know why other staff members did not put music on for their relative during personal care.

●Care plans showed where people had any specific needs relating to a disability or religion. Records showed people enjoyed the visits from religious organisations.

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

●Relatives told us they felt involved in people's decision making. One relative told us, "We can see [the care plans] if we want to, and the medicines sheet, and they tell us if they call the GP." Another relative told us they had contributed to care plans and staff had asked, "Lots of questions before [our relative] came here, about their likes and dislikes." Care plans recorded how people had been involved in making decisions about their care and also reflected their views and opinions. For example, any clothing preferences.

●Information was available for people on how to contact advocacy services should they need to. Advocacy services provide help to people to represent their views and opinions.

Respecting and promoting people's privacy, dignity and independence

●People told us staff were respectful of their privacy. Staff told us, and we observed they would knock before entering a person's bedroom.
●People told us staff promoted their independence and several people told us they had their own phones, so they could continue to keep in touch with family and friends.
●Care plans identified where people were able to manage any of their care needs independently and staff told us how they helped to promote people's independence.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now remained the same, requires improvement.

People's needs were not always met. Regulations may or may not have been met.

At our previous inspection we found people had not always received personalised care, meaningful activities and regular baths or showers. At this inspection records showed people were offered regular baths or showers and had opportunities to take part in different activities. This was an improvement and the provider was no longer in breach of Regulation 9 of the Health and Social Care Act 2009 (Regulated Activities) Regulations 2014. However, some improvements were still required to ensure people received personalised care at busy times of the day.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control.

- At times some people did not always receive personalised care as care staff were busy and not always available to assist them in a responsive way. However, staff with responsibility for supporting people with activities engaged consistently well with the people they cared for. They employed calm, personalised, responsive and creative approaches to understand and engage people with activities they would enjoy. We observed these staff provide one to one care as well as group activities for people.
- We saw people living with dementia were supported with items and belongings that gave them comfort. Staff were knowledgeable about this and told us how they helped support people with this.
- The provider was in the process re-writing care plans and risk assessments to ensure they were fully updated them . As mentioned elsewhere in this report, we found those care plans and risk assessments that had been updated were reflective of people's needs and this helped to ensure people received consistent care. However, where the care plans and risk assessments had not been updated, this meant that people were sometimes at risk from inconsistent care.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- The service identified people's information and communication needs by assessing them. People's communication needs were identified, recorded and highlighted in care plans. For example whether people had any additional verbal, sight or hearing needs.

Improving care quality in response to complaints or concerns

- There was a complaints policy and procedure in place. Records showed any complaints received had been investigated and response provided to the complainant. Information on how to make a complaint was

available within the service. In addition, the provider had a system where people and relatives could leave feedback in the main reception area electronically.

End of life care and support

●Care plans and risk assessments were in place for when people would require care at the end of their lives. Staff understood the importance of developing end of life care plans with people, when this was required.

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 the last inspection this key question was rated as inadequate. At this inspection this key question has now remained the same, inadequate.

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

At our previous inspection in November 2018, we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because systems and processes designed to identity shortfalls in quality and safety and ensure improvements were not always effective. In addition, records were not always up to date, learning from incidents was not always demonstrated, partnership working required improvement and meetings with families were not regularly held. At this inspection we found the provider had not made sufficient improvements and was still in breach of Regulation 17.

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

- Systems and processes designed to identify shortfalls and to improve the quality and safety of care were not effective and people were exposed to potential risks as a result.
- Mattresses and cushions were checked each month to ensure they were clean. The registered manager confirmed no action had been taken in response to the last audit completed on the 2 and 3 May 2019 that had identified a total of 24 mattresses that had shown staining on the last check. The registered manager told us they were absent at the time of this audit and no actions had been taken in their absence to replace those mattresses identified by the audit. This showed a failure for actions to be taken to audits to improve the quality and safety of services for people.
- We found other shortfalls in medicines management and clinic room processes as reported elsewhere in this report. This showed a failure of audits to ensure these areas were assessed and monitored to ensure they were safe and risks mitigated.
- Whilst care plans were in the process of being re-written to address the concerns from our previous inspection, there was still a significant number of care plans that had not yet been re-written. We found where care plans had not yet been re-written, they did not always contain accurate and up to date information on people's care needs. In addition, confidential information had not always been stored securely. This was because we found care plans were left unattended in communal areas.
- The registered manager told us staff had training on an electronic system and also as part of their induction. However, the provider also expected staff to complete 'face to face' training annually. At the time of our inspection, the registered manager told us whilst most staff had completed electronic safeguarding training, there were 40 staff (out of 54 staff) who had not yet completed the provider's annual safeguarding 'face to face' training. We were concerned this training had not been completed in line with the provider's expectations.

● The provider's system to plan staff deployment was not effective. This was because it did not ensure sufficient staff were available over predictably busy times, such as lunchtimes to ensure people received timely care. The registered manager told us they did not monitor nurse call-bell response times as a way of providing assurances people received timely care. Some people had raised concerns with us over the length of time they had to wait for staff to assist them when they ad used their nurse call bell.
● The provider's audit on people's mealtime experiences completed in February 2019 found people who required staff assistance had been left with their meal in front of them whilst staff were busy doing other things. Their audit in April 2019 showed this had improved, however we could not see this improvement had been sustained.
● The provider's February 2019 mealtime experience audit also found televisions had been left on in the lounge and staff were shouting to each other across the dining room. On day one of our inspection we found this had also not improved.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

●Statutory notifications for notifiable events and incidents had not always been submitted to CQC in a timely manner as required.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Continuous learning and improving care
● Whilst the provider had made some improvements since our last inspection, they had failed to make sufficient progress on some of the concerns we identified at our last inspection. This included auditing the service effectively to identify shortfalls, taking effective action to improve the service, accurate and up to date records and staff deployment.
● The provider had reviewed any behaviours that challenged in a person centred way. This had led to trying different activities for some people living with dementia and had resulted in positive outcomes for some people.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility.
●The provider had had taken a person-centred approach to care plan and understand behaviours that challenged. However, this approach was not yet demonstrated by all staff.
●People did not always experienced person-centred care as staff deployment over lunchtime meant some people did not receive timely care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements.
●Charnwood had a registered manager in post. Registered managers, along with registered providers have legal responsibility for how the service is run. The provider had policies and procedures in place to help support the governance of the service.
●It is a legal requirement that a provider's latest CQC inspection report is displayed at the service where a rating has been given. This is so that people and those seeking information about the service can be informed of our judgments. The rating from the previous inspection was displayed at the provider's office address.

Engaging and involving people using the service, the public and staff, fully considering their equality

characteristics

●The provider had spent time with people, relatives and visiting professionals to ask their views about the service and used to help identify if improvements were required.

● Staff we spoke with told us they could contribute their views and felt listened to.

●Staff meetings were held and provided opportunities for staff to share their views.

Working in partnership with others

●The service had worked in partnership with other professionals. For example, a pharmacist was checking on medicines systems on the day of our inspection. In addition, we saw care had been provided to help ensure people attended any hospital or specialist health appointments.

Other professionals such as advocates were also involved in people's care.

●Advice and guidance from other healthcare professionals was known by staff and included in people's care records for reference. For example, when district nurses or pharmacists were involved in people's care.

●One relative told us staff had planned their relative's discharge from hospital back into the service well. They told us it had gone very smoothly, and staff had made sure they had obtained any equipment that would be required for their relative's care.

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 Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents Statutory notifications had not always been submitted as required.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's health, safety and welfare were not always reduced. People were not protected from the risks associated with infection. Medicines were not always managed safely. People were not always assisted to mobilise safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes designed to assess, monitor and improve services and mitigate risks were not always effective. Shortfalls in the quality and safety of services ad not always been identified. Actions had not always been taken in response to identified shortfalls. records were not always accurate or stored confidentially. Statutory notifications had not always been submitted in a timely manner as required.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care Treatment of disease, disorder or injury	Staff were not always available to provide care in a timely manner