SHC Clemsfold Group Limited

Upper Mead

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service:
Upper Mead is a residential and nursing care home providing care and support to 37 people aged 65 and over at the time of the inspection. The service can support up to 48 people living with dementia and physical care needs.

Upper Mead is a large, purpose-built premises and is split across two floors. People live on both the ground and the first floor of the service. There is a self-contained area on the ground floor of the service where people with dementia support needs live called 'Chestnut Lodge'.

Upper Mead is owned and operated by the provider Sussex Healthcare. Services operated by the provider had been subject to a period of increased monitoring and support by local authority commissioners. As a result of concerns raised, the provider is currently subject to a police investigation in relation to incidents that occurred between 2016 and 2018. The investigation is on-going, and no conclusions have yet been reached.

People's experience of using this service and what we found:
People told us they felt safe at the service. However, people were not always protected from risks. Risks associated with suicidal thoughts, constipation management and behaviours of concern were not consistently assessed and mitigated. Staff practice and reporting systems to safeguard people from abuse were not always effective. We have made a recommendation for improvement.

Lessons were not always learnt, and actions taken to investigate safety incidents and prevent them re-occurring. Protocols for the use of 'as required' medicines lacked detailed and failed to provide sufficient guidance to staff.

The care and treatment of people was not always appropriate and did not always meet their specific needs. Care plans did not evidence that people were being involved to the maximum extent possible in their care or that their preferences were always being taken into consideration. Best practice guidance was not always considered when assessing people's care needs. Care plans were not consistently holistic, and people were not routinely supported with their mental health needs. The risks associated with social isolation had not always been assessed or mitigated. We have made a recommendation for improvement.

Quality assurance frameworks were in place; these were not consistently effective in driving improvement or identifying shortfalls. Care plans were reviewed on a monthly basis; however, these reviews were not effective in identifying shortfalls with the poor provision of concern or how improvements could be made.

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. Staff felt supported in their role and spoke highly of the registered manager. Relatives and

people were complimentary about the caring nature of the service. People had access to a wide range of communal activities.

People received a balanced diet which met their individual needs and took into consideration their preferences. People spoke highly of the food provided. Staff were skilled and had received training on dementia care. Staff had spent time getting to know people and were knowledgeable about their likes, interests and hobbies.

Staff were respectful and warm when they spoke about people. We observed kind and caring interactions. People were supported to be independent in their personal care and mobility. Safe recruitment practice was operated, and people received their medicines in a dignified manner.

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

Rating at last inspection:
The last rating for this service was Requires Improvement (report published 22 February 2019). The provider was found to be in breach of two regulations. Regulation 9 – Person Centred Care and Regulation 17 – Good Governance. Requirement notices were served, and the provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection, some improvements had been made but the provider remained in breach of Regulation 17 - Good Governance and was also found to be in breach of Regulation 12 – Safe Care and Treatment.

The last rating for this service was Requires Improvement (published 22 February 2019). The service remains rated Requires Improvement. This service has been rated Requires Improvement for the last two consecutive inspections.

Why we inspected:
This was a planned inspection based on the previous rating. You can see what action we have asked the provider to take at the end of this full report.

Enforcement:
We have identified two breaches of regulation in relation to safe care and treatment and good governance.

We had previously imposed conditions on the provider's registration. The conditions are therefore imposed at each service operated by the provider. CQC imposed the conditions due to repeated and significant concerns about the quality and safety of care at a number of services operated by the provider. The conditions mean that the provider must send to the CQC, monthly information about incidents and accidents, unplanned hospital admissions and staffing. We will use this information to help us review and monitor the provider's services and actions to improve, and to inform our inspections.

Follow up:
We will request an action plan for 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always Safe.

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was not always Effective.

Details are in our Effective findings below.

Is the service caring?

Good

The service was 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.

Upper Mead

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 Care Act 2014.

Inspection team:
This inspection took place over two days on 20 and 21 February 2020. On 20 February 2020 the inspection team consisted of two inspectors, a registered nurse specialist advisor 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.

On 21 February 2020 the inspection team consisted of two inspectors and a registered nurse specialist advisor.

Service and service type:
Upper Mead is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided.

The service had a manager registered with the Care Quality Commission. 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.

Notice of inspection:
This inspection was unannounced.

What we did before the inspection:
Before the inspection, we reviewed information we held about the service. We considered the information which had been shared with us by the provider as well as the local authority, other agencies and health and social care professionals.

We looked at safeguarding alerts which had been made and notifications which had been submitted by the provider. A notification is information about important events the provider is required to tell us about by law. This is necessary so that, where needed, the Care Quality Commission (CQC) can take follow up action.

We used the information the provider sent us in the Provider Information Return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection:
We spoke with 10 people who used the service and eight visiting friends and relatives about their experience of the care provided. We spoke with three nursing staff; the administrator, the registered manager, two activity staff, the chef, a member of housekeeping, six members of care staff and the provider's nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included nine people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service were reviewed.

After the inspection:
We continued to seek clarification from the provider to validate evidence found. Further information was provided to the inspection team via email. We gained feedback from two staff members and three relatives via telephone.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. This was because staff's knowledge on safeguarding varied. Risk assessments were not consistently detailed and failed to provide sufficient detail on how to manage the risk. At this inspection, this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management:

- Care and support was provided to some people who could display behaviours of concern. Behaviours included verbal and physical aggression, agitation, shouting and screaming. Challenging behaviour care plans were not consistently in place and where they had been completed, they lacked sufficient guidance on how to support the person in a consistent and safe manner.
- Guidance produced by the Alzheimer's Society advised that for people living with dementia, the display of challenging behaviour can often be a sign of communication or the person trying to express a feeling and care staff should monitor for specific triggers. Staff members told us that one person could display behaviours of concern which included agitation, shouting and physical aggression. Measures to manage these behaviours were not documented in the person's care plan. For example, a behaviour of concern care plan was not in place and a risk assessment had not been completed.
- A behaviour recording sheet was in place for this individual which referenced behaviours such as being aggressive towards staff, throwing cups of tea and verbal aggression. Staff members told us that they found through offering the person their favourite sweets and ensuring their favourite music was playing that these steps helped to de-escalate the behaviours of concern. Whilst staff turnover at the service was minimal, the service occasionally used agency staff. The failure to implement a care plan with clear guidance on how to manage these behaviours meant that for staff members who were not familiar with the person, guidance was not readily available. This increased the risk of the person not receiving support in a consistent manner.
- Another person's care plan identified that they could display behaviours of concern and staff confirmed this. Documentation reflected that this person displayed behaviours which also included hitting other people at the service and staff. Whilst a behaviour of concern care plan was in place, the information provided lacked detail on any triggers and a functional analysis of the person's behaviour had not been completed. The care plan also failed to reflect that the person was known to throw items. Staff and people living at the service reported that this happened on a regular basis. One person told us, "One person often throws things at me."
- The provider's and registered manager's oversight of behaviours of concern was ineffective and placed people at risk of harm. For example, where incidents of challenging behaviour had occurred, staff were not always using monitoring and recording systems effectively, so it was not evident that people had been supported safely.
- Behavioural monitoring charts were not consistently completed when people displayed behaviours of concern and incident forms had not always been completed when people displayed physical aggression. For example, in January 2020, a person was recorded as hitting another person within care staff daily notes.

Behavioural monitoring forms failed to reference this physical aggression and an incident form had not been completed and consideration to raising a safeguarding concern had not been made.

● Between 4 January 2020 and 13 February 2020, we found nine recorded incidences whereby a person had hit other people and staff. Documentation also reflected incidences whereby the person had tried to kick other people and tried to bite a staff member. These incidences had not been raised as potential safeguarding concerns and these behaviours had not been escalated to consider how best to support staff, the person and other people living at the service. We have further reported on the failure to effectively audit behaviours of concern within the 'Well-Led' domain of the report.

● We brought these concerns to the attention of the registered manager who was responsive to our concerns, took prompt action and provided assurances that appropriate action would be taken. Actions included a referral to the crisis intervention team who visited the person four days after the inspection and a safeguarding concern was raised. The registered manager also completed an audit of behaviours of concern after the inspection to consider ongoing actions required.

● Risks associated with people's mental health needs were not consistently assessed. For example, one person had been expressing their wish to die. Nursing notes from January 2020 reflected that one person was shouting that they wanted to end their life and used their hands to gesture a gun towards their head. Staff members told us that this person often expressed their thoughts around ending their life. We discussed these concerns with the registered manager who advised that the person was discharged from the mental health team in 2018. The care planning process failed to identify and consider if a re-referral was required and a corresponding risk assessment had not been implemented.

● Another person's care notes reflected that they wanted to go to sleep and die. Where people had expressed suicidal thoughts and ideations, risk assessments had not been implemented to consider and asses how best to support the individual and what strategies might be helpful to keep the person safe.

● Documentation for one person identified that they expressed their wish to die and made comments around not eating so that they would die. Care staff's daily notes reflected that the person often refused to eat and drink. A mental health wellbeing care plan was in place which identified that they were living with depression and were prescribed an anti-depressant due to low mood and suicidal thoughts. However, a subsequent risk assessment had not been implemented to consider the associated risks with the person displaying suicidal thoughts.

● Poor risk management left people with suicidal thoughts and ideation at risk of not receiving appropriate care and support.

● Some people were at risk of constipation due to their health and physical conditions. Constipation assessments had been completed, however, actions to manage the risk of constipation were not consistently safe or effective. One person's bowel monitoring chart reflected two incidences in February 2020 where they had not experienced a bowel movement in four days. Their bowel movement chart referenced that after three days staff should notify the nurse on duty. The nurse on duty should then follow the person's PRN guidance (as required medicine guidance for the management of constipation).

● The nurse on duty told us that it was common for the person to go three days without a bowel movement, however advised that on the third day (of non-bowel movement) action should be taken. They commented, "If a person hasn't experienced a bowel movement in three days, we would offer PRN medicines, offer prune juice and increase their fibre intake." Nursing staff presented as knowledgeable about the steps to take. However, the actions advised by the nursing staff were not consistently being followed. Nursing notes failed to reflect that action was taken after three days, such as offering PRN medicine or high fibre food.

● In January 2020, documentation reflected that one person did not open their bowels for three days. Care records demonstrated that they were prescribed a medicine to help manage their bowels. The risk of constipation had been identified, however, risk assessments failed to identify that the person was administered medicine to help promote healthy bowels along with as required medicine (PRN). Information was not documented within the risk assessment on when to give the PRN medicine and what to do if the

medicine failed to take effect. Poor risk management meant the person was exposed to harm as guidance was not available on the steps to take when the individual did not experience a bowel movement. We brought these concerns to the attention of the registered manager who provided assurances that action would be taken.

The failure to effectively mitigate risks associated to service users was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Other risks were managed safely. Risks associated with catheter care were managed safely. Guidance was in place on how to safely care for the catheter site and the signs of infection to monitor for.
● Many people at Upper Mead continued to require support to manage risks associated with their mobility and manual handling support needs. Moving and handling risk assessments were in place which considered the equipment required, number of staff and any factors which might prevent an unsafe transfer.
● The management of epilepsy was safe. Robust risk assessments were in place which provided guidance on how to manage seizure activity alongside guidance on the steps required in the event of emergency rescue medicines being needed.
● A business continuity plan was in place which considered the actions to take in the event of loss of power or having to evacuate the service.

Systems and processes to safeguard people from the risk of abuse:
● At the last inspection in November 2018 concerns were identified that some staff were not confident about who they could speak with outside of the provider's organisation if they were concerned about people suffering from abuse. This was discussed with the registered manager who took steps to refresh staff's learning.
● At this inspection staff demonstrated a clear knowledge on how to raise safeguarding concerns. One staff member told us, "If I had any safeguarding concerns, I would raise them with the registered manager or operations director. If I felt they were not taking action, I know that I can also raise concerns with the local authority." Another staff member commented, "People can become withdrawn don't want to come out and do activities. UTI's and bruises could be a sign of safeguarding. Any concerns I would go to the manager and there is a safeguarding team."
● Staff had received safeguarding training and the registered manager told us that they regularly checked staff's understanding on safeguarding during handover and supervisions. Whilst staff had received safeguarding training, robust systems were not in place to ensure safeguarding concerns were raised when required.
● Handover meetings were held every day and these meetings considered safeguarding concerns alongside incidences and untoward events. We reviewed the handover documentation dating back to 14 January 2020 and found that incidences of physical aggression between people had not been discussed or flagged as a concern, despite the daily handover covering this specific topic. For example, on the 13 February 2020, a service user hit another service in their bedroom. Daily notes reflected that the person experienced an emotional outburst after being hit. The handover documentation from the 14 February 2020 failed to flag this incident as a potential safeguarding concern and failed to provide any handover to staff on how to support the two people.
● Staff members and the registered manager confirmed that any incidences of abuse between people should be raised as a safeguarding concern. Whilst staff provided this verbal assurance, documentation reflected that staff were recording incidences of physical aggression, yet consideration had not been made to raising safeguarding concerns.
● A number of people told us that they felt safe living at Upper Mead. However, feedback from a couple of people living on the dementia lodge raised concerns. One person told us, "Another person hit me recently."

Another person commented, "They have the freedom they need but we pay for it."
● During the inspection process, the registered manager took action to raise safeguarding concerns and review internal processes and systems.

We recommend that the provider seeks guidance from a reputable source around operating robust safeguarding processes and systems.

● Despite the safeguarding concerns, a number of people and their relatives told us that they felt safe living at Upper Mead. One person told us, "I feel absolutely safe here, no one threatens me." One visiting relative told us, "Yes, we feel they are safe here."
● Where safeguarding concerns had been raised and investigated by the Local Authority, staff and the registered manager worked in partnership with the Local Authority to implement lessons learnt. The registered manager told us, "Following one safeguarding concern where it was identified that we failed to assess someone properly following their discharge from hospital. We have now changed our practice and always conduct a pre-admission assessment when someone is returning back from hospital just to ensure that we can meet their needs and they are safe to return to Upper Mead."

Staffing and recruitment:
● People's feedback about staffing levels at the service was mixed. Some people felt that staffing levels were sufficient within the service. One person told us, "Yes (enough staff) I always get help when I need it." Another person told us, "Yes, enough staff, I've never needed to wait long for help." Other people raised concerns. One person commented, "Not enough staff." One relative told us, "Mainly enough staff, but occasionally there could be more staff."
● Observations of care demonstrated that staff responded promptly to people's needs and call bells were answered in a timely manner. Staff members felt staffing levels were sufficient and that they had time to spend with people.
● A dependency tool was in place to determine staffing levels based on people's individual needs. This assessment tool considered people's communication, social dependency, behaviour and other areas of care. People's assessed level of need then filtered into the provider's dependency tool which calculated the number of staff required on each shift. The provider also utilised a safer staffing tool and 24 hour shift planner to monitor and review the deployment of staff.
● People's individual level of need were not consistently reviewed to assess and consider if staffing levels remained sufficient. For example, one person's dependency assessment tool had not been reviewed since July 2019 despite a number of incidences in January 2020 and February 2020 whereby they had hit other people and staff. This meant staffing levels had not been reviewed to consider if staffing levels on the dementia lodge remained sufficient. We brought this to the attention of the registered manager who confirmed that they would review staffing levels in light of the recent incidences on the dementia lodge. Following the inspection, the registered manager advised that one to one care had been implemented for one person who displayed behaviours of concern.
● There were safe systems and processes for the recruitment of staff to ensure they were suitable for their roles. This included undertaking appropriate checks with the Disclosure and Barring Service (DBS) and obtaining suitable references. Nurses deployed were checked by the registered manager and provider that they were registered with the Nursing and Midwifery Council (NMC) and were fit to practice.

Learning lessons when things go wrong:
● Systems in place for staff and management to report, review, investigate safety incidents and act to prevent them re-occurring were not always effective. Staff were not always identifying or completing accident and incident forms as required or reporting incidents internally or externally for further review. This

increased the risk that incidents would not be investigated and acted on to prevent them from happening again.
● The management of people's needs such as behaviours of concern and constipation were issues, we had found at other of the provider's locations. This information had not led the provider acting to prevent similar risks to people at Upper Mead being reduced.

Using medicines safely:
● Support was provided to a number of people prescribed a specific type of PRN (as required) medicines to manage behaviours of concern. Protocols were in place for the use of PRN medicines. However, these lacked detail on the steps to take before administering the medicine so that the medicine was the last resort. This increased the risk that people were being administered medicine before all appropriate steps had been taken to manage the behaviours in another way.
● We brought these concerns to the attention of the registered manager who reviewed PRN protocols during the inspection.
● Medicine audits were completed weekly and monthly. These audits failed to identify that PRN protocols were not always fit for purpose. We have further reported on the auditing process within the 'Well-Led' domain of the report.
● Staff completed Medicines Administration Records (MAR) which were up to date and accurate. The numbers of medicines on the MARs when reviewed matched with the numbers of medicines in stock.
● People received their medicines on time. Safe systems were in place for the storage and disposal of medicines, this was checked and recorded by two trained nurses.
● People received their medicines on time and in a dignified manner. Medicines were administered by registered nurses who received regular training. Nursing staff were aware of good practice guidelines and this was observed in practice.

Preventing and controlling infection:
● The service was clean and hygienic. The provider employed cleaning staff who carried out daily cleaning of all areas and equipment in use at the service. Infection control audits were completed on a regular basis and an infection control lead was in post.
● Nursing and care staff used personal protective equipment such as gloves and aprons to reduce the risk of cross contamination. Laundry bags were appropriately labelled to distinguish soiled laundry. Hand sanitisers were available throughout the service for people, staff and visitors to use.
● In January and February 2020, the service had supported a number of people with chest infections. Measures were followed to manage the infections and prevent the spread of infection. One staff member told us, "We regularly watch out for the signs of an infection, such as high temperature, cough and cold. We inform the GP, monitor their nutritional intake and also devise a short-term care plan around the management of the chest infection."

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 the last inspection this key question was rated as Requires Improvement. This was because staff's knowledge of the Mental Capacity Act 2005 (MCA) varied and pre-admission assessments were not consistently detailed. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law: Staff working with other agencies to provide consistent, effective, timely care: Supporting people to live healthier lives, access healthcare services and support:

- At the last inspection in November 2018 concerns were identified that pre-admission assessments lacked detail and failed to include information on people's social history, likes and preferences. At this inspection, we found that some improvements to the pre-admission assessment had been made. For example, the admission assessment now considered religion, sexuality and disability. However, further work was required to ensure people's needs were holistically assessed and the delivery of care and treatment was not consistently delivered in line with evidence based best practice guidance to achieve effective outcomes for people.
- Guidance produced by National Institute for Health and Clinical Excellence (NICE) advises that 'health and social care professionals should consider the specific needs of people arising from their dementia along with other care needs such as depression and other mental health needs. Care plans should record and assess those needs.'
- Suitable arrangements were not consistently in place to support people with their mental health needs. Mental health well-being care plans had been completed, yet these failed to assess and consider how best to support people with their mental health needs such as depression in line with best practice guidance. One person's care plan identified that they were not living with a diagnosis of depression, yet a hospital discharge summary from 2019 reflected that they were living with depression. We brought this to the attention of the registered manager who amended the care plan during the inspection. Whilst the care plan was updated to reflect that were living with depression, guidance was not included within the care plan on how to support the person holistically. For example, the person's care plan identified that they had suffered several losses within their life and were also living with a sight impairment. The care planning process failed to consider all these factors and how best to support the person with their mental health needs.
- Assessments of some people's sexuality and relationship needs had not considered appropriate, evidence-based practical social support, advice and guidance. This increased the risk that they might not receive effective support to meet their needs in these areas of their lives. One person's care plan referenced that they could call out for one person in particular. We asked staff who this person was to the individual. Staff members provided varying accounts of the relationship. Some staff explained that the two were friends, whereas other explained that they were partners. The importance of this relationship to the person was not reflected within the care plan. The registered manager confirmed that staff had not received

training on sexuality and relationships for people living with dementia but advised that this was something they were looking into.

The failure to holistically assess people's needs was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider was using nationally recognised tools to track and monitor people's health outcomes, such as MUST (malnutrition universal screening tool) tools to monitor people's nutritional needs.
● For people living with a neurological condition, a DISDAT (disability distress assessment tool) was completed to help staff understand when people may be upset or in pain. Staff were knowledgeable about the signs and symptoms that might indicate a person was in pain or experiencing discomfort.
● People were supported to attend healthcare appointments and links with a local GP practice had been established. A GP visited the service every week to provide guidance and support. People had also been assisted to see other healthcare professionals including dentists, chiropodists and opticians.
● People were supported to receive co-ordinated care when they used or moved between different services. This included staff passing on important information when a person was admitted to hospital.
● Staff used a standardised system for recording and assessing baseline observations of people's health indicators. This included temperature, pulse, blood pressure and respiratory rates. The system was called National Early Warning Score (NEWS). NEWS was designed to ensure that people's health needs were effectively monitored and, if necessary, people could be supported to receive or access healthcare support and services quickly. Staff were expected to complete NEWS as and when required, if they noticed a person appeared or was unwell. From records we sampled, we saw that this system was being used appropriately at the time of the inspection.
● Relatives felt that their loved one's care needs were being met. One relative commented, "I am confident that they would get the doctor in to see them if they were unwell." Another relative told us, "They recently got medical help when our relative had a health problem."
● The oral care of people had been assessed and care plans implemented.

Adapting service, design, decoration to meet people's needs:
● The lower floor of the service had a dedicated lodge for people living with dementia care. Guidance produced by the Social Care Institute for Excellence advises that the environment can have a huge impact on people living with dementia. The guidance also advises that the use of colour and contrast can be helpful and patterned fabric should be avoided.
● The environment did not always support people living with dementia to lead fulfilling and stimulating lives. Consideration had not been given to the use of colour contrast on the walls and the carpet was patterned. Some people on the lodge enjoyed walking around throughout the day. Walls within the lodge were bare with no objects for people to engage with as they walked around the lodge.
● We discussed these concerns with the registered manager who confirmed that a programme of redecoration was due to take place and people would be involved in the design and decoration of the lodge and the wider service.
● Support was provided to some people living with a sight impairment. Consideration had not always been given to the design of their bedrooms and whether specialist equipment and aids could be used to promote independence. Staff members advised that one person struggled to distinguish between day and night. Steps had not been taken to consider if different light bulbs could be beneficial to help orient the person. We discussed this with the registered manager who identified that referrals to Occupational Therapists would be considered and made if felt appropriate.
● When people moved to the service, they were able to personalise their rooms with their own belongings. People had items of importance displayed in their bedrooms and staff told us how they encouraged people

to personalise their bedrooms.
● The registered manager was working with people to help them choose the design of the curtains in their bedroom along with the design of their bed spreads. Areas of the service had been painted by an ex staff member who was a keen artist.
● The service had a secure courtyard which people could access freely. One person was observed enjoying a cigarette in the courtyard. With pride, the registered manager spoke of their intentions to implement a coffee house in the courtyard and to get everyone involved in the design of the coffee house and with the painting of the coffee house.

Staff support: induction, training, skills and experience:
● Staff told us that they felt supported within their role. One staff member told us, "I feel really supported. Any questions I know I can approach the registered manager."
● An ongoing training programme was available to staff and staff new to the care sector were also required to complete the Care Certificate, covering 15 standards of health and social care topics as part of their induction into working in health and social care. Staff spoke highly of the training provided. One staff member told us, "The dementia training has been really helpful. We all downloaded an app on dementia care which was really interesting. I learnt the importance of talking to people using less complex sentences."
● All staff had received dementia awareness training. One staff member told us, "There are 129 different types of dementia and so many branches of dementia. I find dementia care really interesting." One staff member commented that they would find it helpful to have more training around experiencing life from the perspective of people they supported. Subsequent to the inspection, the registered manager advised that they were looking into virtual dementia training for staff to access.
● A number of staff had received positive behaviour training. Staff feedback that the training was not geared towards people living with dementia but that aspects of the training were useful. During the inspection, we observed a staff member implementing their training into practice. One person was heard getting confused and frustrated. The staff member involved use humour appropriately and diffused the situation. In return the person calmed down and continued having a laugh with the staff member.
● Staff received ongoing support and access to further training to develop their careers. Staff members had been supported to gain leadership qualifications and one staff member was being supported to further develop their career into a leadership role within the service.
● Permanent nursing staff had access to clinical training to maintain their registration with the NMC. One nurse told us, "I've recently had training on venepuncture, catheterisation and NEWS (National Early Warning Score charts). The training is very good here."
● Staff had access to a book of knowledge which they found helpful. The book of knowledge covered key areas such as safeguarding and mental capacity. One staff member commented that it was helpful knowing guidance was readily available on key topics.

Supporting people to eat and drink enough to maintain a balanced diet:
● Staff consulted with people on what type of food they preferred and ensured that food was available to meet people's diverse needs. People told us they enjoyed the food at the service and could always choose something different if they did not like what was planned. One person told us, "They would do something different if we didn't like the menu."
● People spoke highly of the food provided. One person told us, "The food and meals are good." Another person told us, "The food is very good."
● With permission we joined people for their lunchtime meal. Tables were neatly decorated with flowers, condiments and table cloths. The menu was on display along with a menu citing alternative options that people could choose from. Staff took time to check that people were happy with the meal provided and offered support and assistance where required.

● The chef was knowledgeable about people's individual nutrition and dietary needs. They commented that information was regularly shared with them about people's diet and if they required a fortified diet.
● People's weight was monitored on a regular basis and a monthly audit was completed which provided oversight of who was losing or gaining weight. Where required, people had received support from dieticians and Speech and Language Therapists (SaLT).

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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● At the last inspection in November 2018 staff's understanding on the MCA 2005 varied. At this inspection we found improvements had been made. Information on the MCA 2005 was now documented on the staff handover and the registered manager had provided staff with pocket size guides on the principles of the Act.

● Staff recognised the importance of gaining consent from people and this was observed in practice. One staff member told us, "We always offer people choices and respect their right if they want to make an unwise decision."
● A number of people living at Upper Mead either had an active DoLS in place or was awaiting authorisation. An appropriate assessment process had been carried out for each person. DoLS care plans were in place which considered whether an authorised DoLS was in place and if any conditions were attached to the DoLS authorisation.

Good

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 the last inspection this key question was rated as Good. At this inspection this key question has remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

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

- People spoke highly of the service; however, ongoing work was required to ensure people regularly received safe and person-centred care. We have further reported on these concerns in the 'Safe', 'Effective', 'Responsive' and 'Well-Led' domain.
- People and relatives were complimentary around the caring culture of the service. One person told us, "The carers are very kind, they are excellent." Another person told us, "The staff are all so kind, we are all very well looked after." A third person told us, "The staff are lovely, they are all very nice."
- Relatives spoke highly of the care provided to their loved one. One relative told us, "The staff go above and beyond. We are so happy with the care. How staff engage with people is brilliant. We are really happy with the service and the care."
- Staff were aware of the importance of treating people well. One staff member told us, "All the staff are caring. When I show new staff round, I say think of that person as your grandmother and how you would like them to be treated."
- Observations of care demonstrated that people responded well to staff. Staff demonstrated a good understanding of people's hobbies, likes and interests. On the day of the inspection staff were supporting people with a pampering morning. Staff were engaging with people about their past and one staff member was supporting a person to reminiscence about the birds they use to have.
- Staff supported people to maintain their sense of appearance. One person's care plan referenced that they enjoyed looking smart, having their nails done and wearing their jewellery. This was observed in practice.
- People's cultural and spiritual needs were respected. Local religious groups visited the service and on the day of the inspection, a number of people were supported to attend Holy Communion in the communal lounge.
- Staff recognised the importance of human touch and gently supported people, to provide comfort. On the inspection staff were observed providing hand massages to people as part of their pampering morning. People were observed enjoying the massage and enjoying spending one on one time with staff.
- The registered manager and staff recognised the importance of pet therapy. A number of relatives visited with their own pets which people enjoyed and a local pet pals organisation (organisation providing pet therapy for people living in care homes) regularly visited the service.
- Staff greeted people and checked on their wellbeing and comfort. Visitors to the service were welcomed and offered refreshments. People were supported to spend time with their family and maintain that communication. One relative told us, "Visiting is at any suitable time and we are made to feel very welcome."

Supporting people to express their views and be involved in making decisions about their care:
● Staff supported people to make day to day decisions such as what to eat and wear. Observations of care demonstrated that people were regularly provided with day to day decisions.
● Relatives commented that they felt involved in their loved one's care. One relative commented, "The communication from the home is very good." Another relative told us, "Every time I visit, they bring us up to date on our loved one's welfare."
● Further work was required to ensure people were equal partners in their care and actively supported to direct their own health and social care. For example, care plans were reviewed on a monthly basis, however, people and their relative's involvement in these reviews was not always apparent or evidenced. We further reported on communication and involvement in care plans in the 'Responsive' domain of the report.

Respecting and promoting people's privacy, dignity and independence:
● Staff members gave us examples of how they maintained people's privacy and dignity when they supported them with personal care. One staff member commented, "I always ensure when providing personal care that people feel comfortable and if I'm supporting to wash their top half, I'll ensure their bottom half is covered up." One person told us, "Staff are respectful and treat me with dignity."
● People were supported to remain as independent as possible. One staff member told us, "We try to promote independence as much as possible as it's the last bit of their life and we try as it good to make them independent." Another staff member commented, "I encourage people to wash and dress themselves and help if they ask for help, I give a choice of dress and what to wear and they all have the choices they want. "
● Consideration was given to people's requests for male or female staff and these requests were respected. One person told us, "I only want help from female staff and that's always respected."
● Relatives spoke highly of the caring nature of staff and how staff treated their loved ones with dignity and respect. One relative commented, "They are shown respect by the staff."

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. This was because care plans were not consistently person centred. At this inspection this key question has remained the same. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences: 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.

- At the last inspection in November 2018, the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because care plans were not consistently personalised. At this inspection, improvements had been made and the provider was no longer in breach of regulation, but ongoing work was required to ensure care plans remained person centred.
- On a monthly basis, people's care plans were reviewed. However, people's involvement in this review was not always evidenced. Some monthly reviews reflected that staff had spoken to the person, whereas other care plan reviews noted that the person had not been involved with the review. We discussed these concerns with the registered manager who advised that people and their relatives were always offered the opportunity to be involved in their care plan review. Further work was required to ensure this process was documented and evident within the care plan review.
- Care plans were not always presented in a way that people could easily understand. Care and support was provided to a number of people living with a sight impairment. The care planning process did not always ensure and consider how people's communication needs could be met. For example, consideration was not given on how information could be provided in a format that the person would understand and be able to access.
- One person's communication care plan identified that they struggled with their hearing and were living with sight impairment. The person's communication care plan failed to assess and consider how information should be provided and received. For example, whether the person required easy read or large print. We brought these concerns to the attention of the registered manager who identified that ongoing work was required to comply with the requirements of the Accessible Information Standards.
- Information such as the menu and activity planner were displayed in pictorial format within the service.
- Whilst the care planning process failed to consistently consider people's communication needs, staff demonstrated a good understanding of how best to communicate with people. One staff member told us, "For a couple of people we try and use picture cards. It can be hit and miss but we assess people's communication daily and we can tell by people's faces when they're happy or not." Observations of care demonstrated that staff spoke to people using eye contact, sat down to their level and provided people with clear options.

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

● The provider employed dedicated activity staff who organised an array of group-based activities in the service's communal lounge. For people who regularly accessed the communal lounge, their wellbeing was enhanced through regular interaction with people and staff. However, for people who remained in their bedroom, the risk of social isolation was not always assessed and mitigated.

● Care and support was provided to a number of people receiving care in bed. Social care plans were in place, but these failed to identify if the person was at risk of social isolation and the steps required to manage the risk of isolation. One person's social and mental health wellbeing care plan identified that they preferred to stay in their room enjoying one to one chats and activities. Consideration had not been given to the impact of siting within the same four walls day in and day out and whether all steps were being taken to manage and reduce the risk of social isolation.

● Consideration was not always given to people's environment when people preferred to stay in their bedroom or receive care in bed. Some bedrooms were personalised with pictures and ornaments, whereas other bedrooms were bare, with little detail and few images on the wall. Staff told us how one person's bedroom lacked personalisation due to the risk of the person throwing things in their bedroom. Documentation reflected that they had not tried to throw objects in a long time and consideration had not been given to reintroducing objects back into their bedroom to make it personalised for them.

● Activity staff told us that they regularly encouraged people to attend the group activities but respected people's wishes. One activity staff member told us, "Where people don't want to engage in the group activities, we do provide one to one activities and have chats with people." Staff members also told us that in the afternoons if they had time they would often sit and chat with people.

● Activity logs were completed on a daily basis. These considered if the person participated in the activity, declined and their level of engagement. This information was not used in the review of activities and social care plans. For example, where's people had consistently declined to engage in activities, there was no consideration as to whether changes were needed to the activity schedule to ensure people's level of participation and enjoyment improved.

● One person's activity log throughout February and January 2020 identified that they declined to attend any group activities and documented that staff provided one to one chats on three occasions. Their social care plan was reviewed in February 2020 and failed to assess if the provision of one to one activities was sufficient in meeting their needs and reducing the risk of social isolation.

● The service no longer has its own dedicated mini-bus. The registered manager told us, "We use to have a mini-bus and I am now pushing to get one back as all trips now have to be booked in advance and we don't have the ability to take people out on spontaneous trips." Activity staff confirmed that the absence of having a dedicated mini-bus at the service was having an impact. One member of the activity team told us, "Without having a mini-bus we have to book everything in advance and if someone asks on the day that they want to go out, we can't always accommodate that." Three people commented, "We never get out, but would like to and we'd like to get out shopping." Following the inspection, the registered manager confirmed that the service would be getting their own mini-bus in due course.

● The inspection team spent time with one person who enjoyed doing their make-up every day. We asked the registered manager if the person was supported to attend a local make-up shop so that they could continue buying their own make-up. The registered manager advised that due to the impact of the service not having their own mini-bus, the person had not been supported to attend the wider community, such as a local town to access a makeup shop.

● The service had a dedicated dementia lodge (Chestnut Lodge). Access in and out of the lodge was via a coded locked door. A number of people living on the Lodge were supported to access the communal lounge within the service and leave the lodge. However, records demonstrated that for a couple of people they had not been supported to leave the Lodge or even access the courtyard for over six months. Whilst a number of

these months were winter months, the provider was unable to demonstrate that support was in place for everyone to leave the lodge and access fresh air.
● Guidance produced by the Social Care Institute for Excellence (SCIE) advises that for people living with dementia who walked a lot or spent time in gardens, spending time outside can make them feel relax and calm. Two people living on Chestnut Lodge use to be keen walkers as stated in their care plan. Documentation also reflected that they had displayed recent behaviours of concerns. Care records demonstrated that they had not been supported to leave the lodge in over six months.
● We received mixed feedback from people living on the dementia lodge regarding activity provision within the dementia lodge. One person told us, "We don't get much entertainment that is true." Another person told us, "It would be nice to get things that we want to learn and always have something to occupy our minds." Whereas other people spoke highly of the activities within the communal lounge.
●Information on people's past history had been captured and documented. One person's care documentation reflected they had lived in Germany and spoke fluent German. During the inspection, the person was observed stating that they wished they had someone to speak German with. Staff members advised that another person living in the service also spoke German. However, staff advised that the two had not been introduced or encouraged to meet up so that they could speak German together

We recommend that the provider seeks guidance from a reputable source about the importance of regularly accessing outside space along with the provision and evaluation of person-centred activities for people at risk of social isolation.

● Subsequent to the inspection, the registered manager advised of a recent initiative that they had implemented whereby note books had been placed in people's bedrooms. The purpose of these note books were for staff to record when they popped in and had a chat with people. The registered manager also added that measures had been implemented for one person to have a pamper day once a week where they get their hair and nails done and spend time in the communal areas.
● A range of group activities took place on a daily basis. These included bingo, arts and crafts, musical sessions and other activities. The communal lounge was the hub of the service with many people enjoying spending their time in the lounge engaging with staff and other people. For people who enjoyed accessing the communal lounges, the provision of activities and social interactions was enhancing their life and promoted positive outcomes for people.
● Staff spoke highly of the activities provided. One staff member told us, "There are always so many activities going on and there's outings bus trips. There's a lot of activities stuff so you've got extra person to offer different activities. This morning one lady didn't want to join in, so I got a puzzle and she joined in with me doing that so it's having options."
● A number of people attended the communal lounge but enjoyed pursing their own hobbies and interests but in the company of others. One person enjoyed working on their jigsaw puzzles whilst another person enjoyed spending time painting.
● During the inspection, we observed people and staff engaging in a musical session. A member of the staff team was observed singing and playing their guitar. People had access to a music book with lyrics and staff and relatives were observed singing along. The staff member told us that the music book had been made in conjunction with people and now contained the lyrics for a number of songs that were pertinent to people.
● People and relatives who enjoyed spending time in the communal lounge spoke highly of the activities. One person told us, "I like the entertainment, I enjoy bingo, exercises and musical items."
● Activity staff had spent time gathering information on people's life histories to create booklets which contained key information on people's hobbies, interests and past memories. A member of the activity team told us, "We use this information when planning activities. For example, a number of people enjoyed flower arranging so we've added that to the activity programme."

Improving care quality in response to complaints or concerns:

● Arrangements were in place to record, investigate and respond to any complaints raised with the service. We saw evidence that complaints received had been responded to and managed appropriately.

● People and their relatives told us they knew how to raise a concern if they had any worries. One person told us, "No complaints at all and I feel I can always say something if needed." One relative told us, "Any complaints I would discuss them with the manager." One relative told us how they raise a minor concern with the service but that their concern was resolved the same day. They commented, "They responded in such a way to make us that our concerns were taken seriously."

● The provider had received a number of compliments since the last inspection. Comments included, 'Thank you to all the staff at Upper Mead.' 'Just wanted to say a huge thank you to all for your wonderful love and care you give to you all your residents.' And 'As Mums health deteriorated it was a comfort to us all to know that mum was always shown kindness and respect, which has been much appreciated by the family.'

End of life care and support:

● The service was providing support to people at the early stages of their end of their life at the time of inspection. Care plans were in place which provided guidance to staff.

● People's wishes for 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR's) were highlighted within their care plan and this information was clearly documented on the staff handover.

● Consideration was given to ensuring that when people passed on at the service, their bodies were treated with dignity and respect. The daily notes for one person who passed on whilst living at the service reflected that the person's body was moved with dignity and respect.

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 the last inspection this key question was rated as Requires Improvement. This was because quality assurance systems were not yet embedded and operating effectively. At this inspection this key question has remained the same. 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: Continuous learning and improving care:

- At the last inspection in November 2018, the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider's quality assurance systems were not yet embedded and operating effectively. The provider's governance framework had also not been able to ensure that staff at all levels understood and had carried out their responsibilities successfully. Quality and safety risks were not always acted on in a timely manner or monitored and managed effectively. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17
- At this inspection we found a range of systems were in place including audits, care plan reviews and daily handover meetings. Despite these systems in place to review and analyse quality performance, these systems were not effective in identifying shortfalls and driving improvement.
- A number of people displayed behaviours of concern. Documentation was in place to monitor and record these behaviours. However, documentation was not always completed or completed accurately. For example, on the 16 January 2020 one person was administered an anti-psychotic medicine due to displayed behaviours around agitation. Nursing notes reflected that the person was displaying this behaviour, yet behavioural monitoring records documented that the person was asleep when the anti-psychotic medicine was administered. The completed documentation did not align. Poorly recorded documentation meant the provider was unable to analyse and review whether the person was supported appropriately. We found that this was a theme throughout the documentation relating to behaviours of concern.
- Communication within the service was not always effective and consequently impacted on the provider's ability to analyse information of concern. On a monthly basis the registered manager submitted a monthly report to the provider's quality team. This report considered areas of care such as incidences between people and staff. The monthly report for February 2020 failed to reflect any incidences of abuse despite documentation reflecting seven incidences between the 1 January 2020 and 4 February 2020. Systems to share and escalate concerns within the wider organisation for analysis were not always effective. Therefore, the provider and registered manager did not always have strategic oversight of concerns happening within the service.
- Risk meetings were held on a monthly basis. The purpose of these meetings were to consider clinical risks within the service including risks identified from the monthly report submitted to the provider's quality team. Ineffective governance systems meant that risks associated with behaviours of concern were not addressed or considered within these meetings and therefore action was not taken to drive improvement.

● Since the last inspection in November 2018 the provider and registered manager had introduced a key worker system whereby key workers (staff members specifically involved in a person's care) were responsible for care plan reviews. The implementation of the key worker role was based on feedback from the local CCG where nurses were completing all care plan reviews. The implementation of the key worker system meant care staff were also responsible for completing care plans reviews. The registered manager advised that it empowered care staff to take on further responsibility whilst driving quality improvement.
● Where reviews of care plans were completed, these did not identify errors or shortfalls in documentation. One person's mental health wellbeing care plan was reviewed January 2020 which identified that a referral to the community mental health team had been made. Yet the review failed to identify that a behaviour of concern care plan was not in place.
● Care plans reviews were not effective in identifying how the care plan could be improved and whether sufficient guidance was available for staff. Monthly reviews also failed to drive continuous learning. Documentation reflected that one person had experienced two hospital admissions, one in December 2019 and one in February 2020. Both hospital discharge summaries reflected constipation as a theme. In December 2019, the person was found to be constipated during a hospital admission and responded well to suppositories. In February 2020, the person was admitted to hospital due to episodes of vomiting secondary to constipation. A continence and elimination care plan was in place which referenced the person's history of constipation. However, guidance was not available on how to promote healthy bowels or what the signs of constipation might be. The care plan was reviewed in January and December 2020. The review process failed to consider the recent hospital admissions and whether any changes to the delivery of care were required to ensure the safe management of constipation.
● Accurate documentation was not always maintained. One person was recently admitted to the service. Their pre-admission assessment identified that they were at risk of pressure sores. However, it failed to identify what support they required with skin integrity and that they were currently experiencing redness in specific areas which heightened their risk of skin breakdown. GP visit records from February 2020 identified for staff to promote oral intake as their skin redness had not yet healed. Nursing staff told us that the person was admitted from hospital with the redness in place.
● Nursing staff were aware of the person's high risk of skin breakdown and advised that they were regularly reviewing it. However, the assessment and care planning process failed to reflect that the person was living with poor skin integrity. Risk assessments or care plans had been completed. Guidance was therefore not available for care staff on how to escalate concerns to nursing staff or how to support the person with their skin integrity.
● Quality audits completed by the provider's quality team and external consultants in March 2019, June 2019 and October 2019 raised concerns around behaviours of concern and care plans not always being in place and failure to analyse behaviours. The provider's service improvement plan noted in March 2019 that action had been taken around identifying triggers and de-escalation techniques for behaviours of concern. This action had been marked as completed on the provider's service improvement plan and had not been regularly reviewed to consider and assess ongoing improvements required.
● Quality audits and care plans were not always effective in driving improvement and ensuring that the care planning process was person centred and holistic of people's care needs. Care plans failed to consider and assess the risks associated with depression, social isolation, sexuality and relationships. One person's care plan and monthly reviews identified that they didn't want to go into the lounge to socialise. The care planning process failed to explore and consider the fact that the person was living with sight impairment and experiencing hallucinations. By failing to pick up these inherit factors the service had inadvertently potentially reinforced isolating behaviours which could have impacted on the person's mental well-being.
● Systems were in place to monitor people's nutritional needs. These systems were not always consistent in driving improvement. In 2019, one-person lost 7kg between March and August 2019. Input from the GP had been sought and supplements provided. The individual's care plan made several references to the person

enjoying bacon sandwiches. We asked the chef if the person was provided bacon sandwiches as a forum to promote calorie intake. The chef was unaware that the person enjoyed bacon sandwiches. Ineffective audits meant there was a missed opportunity for staff to promote the person's calorie intake.

● Accurate documentation was not always maintained. Staff had identified that one person was feeling low and had sought advice from the GP. The care plan and subsequent risk assessments failed to reflect this change and information was not available on how best to support the person.

● Throughout and after the inspection process, the registered manager was responsive to our concerns. After the inspection they completed a behaviour of concern audit which identified the need for improved recording. Referrals to healthcare professionals were made alongside discussions with the local safeguarding team. The registered manager was open and honest and commented, "Any shortfalls, we will work hard to address." However, internal checks and audits failed to identify the concerns found on the inspection and proactively address them.

● The risks and concerns found at this inspection, including inadequate risk management in relation to constipation, behaviours of concern, person centred care and accurate documentation have been highlighted in inspection reports about many of the provider's other services. This information had not led to similar risks to people at Upper Mead being reduced. The provider had failed to act upon known areas of concern, non-compliance and risk to improve the quality of care for people at Upper Mead.

The failure to assess, monitor and improve the quality and safety of services, to mitigate risks, and to maintain accurate records, was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people: How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong:

● A number of people and relatives spoke extremely highly of the service. However, for a number of people living with dementia or at risk of social isolation, positive outcomes were not consistently promoted or achieved. We have further reported on these concerns in the 'Safe', 'Effective' and 'Responsive' domains of the report.

● Relatives and people spoke positively about the atmosphere within the service. One relative told us, "There is a positive atmosphere here." Another relative told us, "There is an open house culture here, family can go and talk to the management at anytime." Observations of care within the communal lounge demonstrated a homely atmosphere with people's artwork on the wall, an array of activities taking place and bonds being formed with relatives and people.

● The inspection team received feedback from relatives and the registered manager on how positive outcomes for people had been achieved. The registered manager advised that one person moved into the service after living on their own. They advised that due to the social aspect of the service they had thrived living at the service.

● Staff and people spoke highly of the registered manager and their leadership style. One staff member commented, "She is firm but fair." Another staff member told us, "The manager is good, and her door is always open; you can always go to her. She would support you as much as she can." One person told us, "The manager does a good job." A visiting relative commented, "I am happy my loved one is here, it's good for them. You couldn't get any better, like a first-class hotel." Another relative commented, "We were recommended to bring them here and we are very pleased they are here. I can't fault this care home."

● The CQC's rating of the home, awarded at the last inspection, was on display at the home and on the provider's website.

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

characteristics: Working in partnership with others:

● Forums were in place to involve staff in the running of the service. Regular staff meetings were held whereby staff could discuss ideas and raise concerns. Staff told us that they felt confident in approaching the registered manager and advised that any suggestions they had were always taken forward.

● Systems were in place to recognise staff's hard work and dedication. The operational director awarded staff or staff teams with a 'star award' to recognise their hard work and celebrate success. In August 2019, a staff member was awarded the 'star award' for completing their level five leadership training.

● 'Resident' meetings were held on a regular basis and people were asked on their feedback on the activities provided and also provided with the opportunity to raise any concerns. Minutes from a meeting in January 2020 reflected that people were given the opportunity to raise and discuss ideas for trips out. Meeting minutes also reflected that one person fed back, 'thank you for making my life so much fun at Upper Mead.'

● Satisfaction surveys were sent out to relatives to gain their feedback. Survey results from 2019 were positive with comments, 'the manager is very welcoming and friendly' and 'my mother seems content and happy.' Satisfaction survey results were also utilised to drive improvement. For example, feedback from one relative resulted in the replacement of carpets within the dementia lodge.

● The registered manager was passionate about building links with the local community and ensuring that the service was integrated into the local community. Every Sunday people from nearby houses visited the service for a Sunday lunch. On the day of the inspection, the service was also opened up to people living nearby who attended for a game of bingo. Neighbours and community groups were regularly invited to help provide and take part in activities for people at the service. This had helped the service build strong relationship links with people and organisations in the local area. The registered manager told us about their plans for the future which included the first pre-school in England to be built on the same site as a care home. The registered manager and operations director advised that plans were moving ahead for the pre-school to become operational in September 2020.

● Staff and the registered manager were clear about the ethos and vision of the service. The registered manager told us, "We are aware the service needs some redecoration, but its home from home." One staff member told us, "It's such a happy home, like a family run service."

● Staff and the registered manager were passionate about building the profile of the service in the local area. The service had recently engaged in a number of local initiatives and staff members had recently raised money for local charities. The registered manager was due to participate in a charity walk for the Alzheimer's society.

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 12 HSCA RA Regulations 2014 Safe care and treatment The care and treatment of service users was not consistently safe. Regulation 12

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 to ensure compliance with the requirements of the Health and Social Care Act 2008 were not effective. Regulation 17.