Ms Mary Mundy

Towerhouse Residential Home

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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Towerhouse Residential Home is a care home providing care and support to people aged 65 and over. The home can accommodate up to eight people in one adapted building. When we inspected eight people were living at the home.

People's experience of using this service and what we found
The provider had not ensured records of people's medicines were accurately monitored and recorded. This meant we could not be sure people received their prescribed medicines safely.

The home was clean and tidy. However, we found concerns in relation to environmental risk and infection control. We observed gaps around fire doors and noted the provider had failed to carry out an assessment of fire doors as recommended by a fire safety inspection in February 2021. Potential trip hazards created by uneven paving in the home's garden had not been identified as a risk.

Staff took the temperatures of people, staff and visitors to the home but had not identified that a faulty thermometer was showing temperatures as consistently low. Exposed grouting and cracked tiles were found in the home's bathrooms. There was a failure to accurately record hot water temperatures that meant people could be at risk of scalding. Out-of-date food was found in the home's fridge and there was no system for checking expiry dates of food items.

People's care records had not always been updated to reflect their current needs and risks. People's risk assessments in relation to COVID-19 were generic and had not been personalised to reflect their specific needs. Information about, and outcomes of health appointments for people had not always been recorded.

The provider had failed to verify staff references to ensure they were genuine. There was no system for ensuring that staff working visas were up to date and included in their records.

People told us they enjoyed the meals provided by the home and were offered choices about their food and drink. However, two people's risk assessments showed they were at risk of choking when eating, but we saw staff were not following risk management guidance for one of these people. The provider had not sought specialist eating and drinking assessments for people at risk of choking.

The provider's quality assurance systems had failed to identify risks and concerns, for example, in relation to temperature checks, medicines and environmental safety.

People were supported to have maximum choice and control of their lives and staff them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. People said they were offered choices and our observations of staff interactions with people confirmed this.

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 on 25 June 2021).

Why we inspected
This was a planned inspection based on the previous rating. However, we brought the inspection forward as a result of concerns received from a local authority in relation to safeguarding, record keeping and infection control.

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

We have identified breaches in relation to people's safety at the home, the quality of care records and the provider's quality assurance and monitoring systems at this inspection.

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

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

The overall rating for the service has changed from Requires Improvement to Inadequate. This is based on our findings at this inspection.

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

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Towerhouse Residential Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by three inspectors.

Service and service type
Towerhouse Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The home is managed by the registered provider who is 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 information we had received from the provider in relation to the home. We spoke to a professional from a commissioning local authority. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give 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.

We used all this information to plan our inspection.

During the inspection
We spoke with three people who used the service and one visiting relative about their experience of the care provided. We spoke with three members of staff including the provider and two care workers.

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

After the inspection
We continued to seek clarity from the provider to validate evidence found. We looked at information relating to quality assurance and risk assessments. We spoke with two family members about their experience of the home.

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 Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely
At our last inspection of 25 February 2021 we found people's prescribed medicines were 'potted up' in advance and not administered directly from the container. Staff who had not directly observed people taking their medicines subsequently completed the medicines administration record (MAR). This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had made improvements to this practice. However, we found other concerns in relation to the safety of medicines.

- The provider had failed to carry regular stock counts of people's medicines. We found that the medicines remaining in containers did not correspond with the numbers of medicines administered to three people. Staff had signed another person's MAR to show a medicine had been given, but the medicine remained in their 'blister pack'. The provider's failure to carry out stock counts of medicines meant people were put at risk of health issues from not receiving prescribed medicines appropriately.
- The provider told us that, in the case of one person, there were medicines left over from a previous month and the pharmacist advised the home to continue to use these. However, there was no record of this.
- People's care plans contained profiles of the medicines they were currently taking. However, we found the medicines profiles for two people had not been updated to reflect their currently prescribed medicines. The provider said they would correct the medicines profiles to reflect people's currently prescribed medicines.

The above is evidence of a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People's medicines were safely stored in a locked medicines trolley within the home's clinical room.
- Staff administering medicines had received suitable training.

Assessing risk, safety monitoring and management
At our last inspection we found the provider had failed to adequately assess risk and ensure safety was monitored and managed. There were no risk assessments in relation to COVID-19, fire safety and environmental risks in relation to building works being carried out at the home. The provider had commissioned an independent fire risk assessment but acknowledged they had not yet carried out some recommendations. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had made some improvements. However, we found further concerns in relation to risk assessment, safety monitoring and management.

● We found gaps below fire doors at the home. This meant people were at risk of rapid spread of fire should there be a fire emergency at the home. The home's independent fire safety risk assessment on 21 February 2021 stated, "A high number of fire doors have major deficiencies", and recommended, "Advise a full survey and inspection of fire doors to ascertain requirements for repair or replacement" within one month. We found that such a survey/inspection had not been carried out. The provider told us an officer from the London Fire Service would be carrying out a safety inspection of the home after our visit. We subsequently contacted this officer who advised us that they would be making recommendations regarding the internal fire doors at the home.
● People living at the home now had COVID-19 risk assessments. However, these were identical and did not reflect individual risks to people, for example, in relation to leaving the home independently.
● Two people had risk assessments which indicated they were a risk of choking when eating. These included guidance for staff on how to reduce and manage risk. However, we saw the guidance for one person was not being followed during a meal.
● The home had installed door alarms following an incident where a person left the home un-noticed by staff. However, no associated risk assessment had been developed for this person. This meant there was no guidance for staff on reducing the likelihood of harm to a person wishing to leave the home unsupervised in the future.
● We observed that paving tiles in the home's garden were laid unevenly, creating a potential risk hazard. This had not been identified during the home's environmental audits. During our inspection two people were using the garden.

The above is evidence of a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had made improvements to fire signage and to an external fire exit.

Preventing and controlling infection
At our last inspection we found failures in the provider's infection control systems. The home's policies and procedures did not reflect up-to-date guidance in relation to COVID-19. COVID-19 risk assessments had not been put in place for people. The provider had not maintained a record of temperature checks and COVID-19 testing for people, staff and visitors. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had made some improvements. However, we found there remained failures in relation to the home's systems in relation to infection control.

● We were not assured that the provider was preventing visitors from catching and spreading infections. Masks and anti-bacterial hand gel were available, and inspectors were asked for evidence of COVID-19 test status at entry to the home. However, although the home was checking temperatures of people, staff and visitors, the records of these checks consistently recorded temperatures between 20c and 30c. The healthy body temperature range is between 36.1c and 37.2c. We asked the provider about this and they produced a different thermometer which was shown to produce a more accurate temperature reading. However, the failure to identify and address the fact that temperature readings had been very low, meant ill-health or infection may have not been identified.
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. We found exposed grouting in shared wet rooms, including around the water outlets. One wet room had several cracked tiles. Paint was peeling off the wall in a bathroom. The provider said they would address these issues immediately. Food, such as sandwiches and a lasagne, that should have been used up to four days before our inspection was found in a fridge. The provider had not carried out daily checks of

use-by dates of food items. This meant people may be at risk of bacterial food poisoning from consuming out-of-date foods. When we raised this with the provider, they immediately disposed of the out-of-date food items.

● We were partially assured that the provider was accessing testing for people using the service and staff. The provider said that regular testing of people and staff was taking place. However, the records of testing for staff were incomplete. This meant we could not be sure the provider was taking appropriate action to reduce the risk of people contracting COVID-19.

● We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed. People's risk assessments had been updated to include COVID-19 risk assessments. However, these were identical and had not been personalised to reflect individual risks to people. We asked the provider about disposal arrangements for PPE and other equipment should there be an outbreak of COVID-19 at the home. They told they had not purchased any separate bins to dispose of PPE and used or soiled items should there be a case or outbreak of COVID-19 at the home.

The above is evidence of a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was meeting shielding and social distancing rules. The home's communal areas are small, but seating was arranged to increase social distancing as far as possible. Staff remained socially distanced except when physically supporting people.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider's infection prevention and control policy was up to date.

● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Staffing and recruitment

● The recruitment records for staff showed two references had been obtained prior to staff commencing work. However, the references for two people were handwritten and had not been verified to ascertain if they were from genuine sources. The provider's failure to verify references meant there was a risk of recruiting unsuitable or unsafe staff.

● Criminal records checks from the Disclosure and Barring Service (DBS) had been carried out for staff. However, the DBS certificates for three staff were more than six years old and the provider did not have a system for ensuring that the criminal records status of staff had not changed in the meantime, such as by seeking regular declarations from staff. We discussed this with the provider who told us she would be seeking updated DBS certificates for staff.

● We found there was no evidence of current eligibility to work in the UK for two staff members. The provider told us they would send us copies of current eligibility status for these staff but did not do so.

The above is evidence of a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

● The records that we viewed did not provide information regarding changes or improvements to the service to ensure that lessons were learnt following any incidents or concerns.

● The provider assured us that improvements were made following incidents or concerns. However, the records we viewed did not show how improvements had been made. However, we saw that external door alarms had been fitted following an incident where a person left the home.

● The provider told us they would make improvements to the forms used by the home so they showed clearly what actions had been taken in response to incidents and concerns.

Systems and processes to safeguard people from the risk of abuse

● The home's systems and procedures for ensuring people were safe from the risk of abuse were up to date and reflected good practice.

● We reviewed the home's safeguarding records. The provider had notified CQC about a recent safeguarding concern.

● Staff working at the home had received safeguarding training. A staff member we spoke with described her role in ensuring people were safe from abuse or harm.

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 Good. At this inspection this key question has now deteriorated to Requires Improvement.. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- We found out of date food in the home's fridge. Further details are contained within the Safe section of this report.
- The care plans and risk assessments for two people identified risks of choking. We observed a lunchtime meal. We saw guidance contained in the risk assessment to reduce the risk of choking was followed for one person, but not the other. We asked the provider about this. They told us one person did not wish to be supported when eating, but this was not reflected in their care plan and risk assessment. The provider had not made a referral to a specialist speech and language therapist to assess and provide guidance in relation to choking risk.
- People were offered a choice of food and drink at each meal. Drinks and snacks were provided to people throughout the day. Fresh fruit and chilled drinks were available for people to take whenever they wished.
- We noted there were no vegetarian or cultural food items on the menu. The provider told us that people currently living at the home had not expressed preferences in relation to alternative diets. We saw that information about people's dietary likes and dislikes was recorded in their care plans. This reflected what the provider and people told us about meals at the home.
- People said they enjoyed the food. One person said, "It's very good and if I want something else they will make it for me." We observed a lunchtime meal. People were offered choices and given second helpings where they wished.

Staff support: induction, training, skills and experience

- Staff members received an induction when they first started work to learn about the home, the people who lived there, policies and procedures and their roles and responsibilities.
- Staff members spoke positively about the support they received to do their jobs. Most staff received regular supervision and appraisal of their development and performance. However, we noted that there was no record of regular supervision for one staff member. This meant we could not be sure all staff members received regular supervision and support to enable them to work effectively with people.
- Staff had received the training and support that they needed to carry out their roles. There was evidence of on-going staff training. which covered a range of areas, including medicines management, safeguarding, health and safety, equality and diversity and infection prevention and control. A staff member said, "I had training when I started work here and I have had more since. The training is quite good and seems to cover everything."
- Staff members demonstrated a good understanding of people's needs. They were knowledgeable about people's individual needs including their preferences, behaviours and communication needs.

Staff working with other agencies to provide consistent, effective, timely care

● Information was shared appropriately with other professionals to help ensure people received consistent and effective care and support.

● People's care records showed that health professionals had been contacted immediately where there were any concerns about people's physical or mental health. However, notes of health appointments and their outcomes were not always recorded in people's care records. People's care plans had therefore not been updated to reflect outcomes of health appointments which meant that staff may not know about health care needs. The provider acknowledged this and told us they would ensure records of GP and other health appointments would be recorded in future and this information would be used to update people's care plans and risk assessments.

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

● The layout of the home was suitable for people's needs. The premises were well lit and decorated. There were two ground floor bedrooms for people with mobility needs

● People shared shower rooms with one other person with direct access from their bedrooms. These were provided with locks to people's doors when in use to ensure privacy. A bathroom was available for people who preferred to bathe. However, we found cracked tiles and exposed grouting in the newly refurbished bathroom, further details of which are contained in the Safe section of this report.

● People's bedrooms were well decorated and personalised with items of their choice. A person who had recently moved to the home said, "I've been able to make my room very homely."

● Outdoor space with seating was accessible to people and their visitors.

Supporting people to live healthier lives, access healthcare services and support

● People's health needs were regularly reviewed. A local GP visited the home on a regular basis. However, we found that outcomes of health appointments were not always recorded. The provider had not made referrals for speech and language therapy assessments for two people who were identified as being at risk of choking.

● People were supported by staff to keep as mobile as possible. Regular exercise activities took place. The provider told us regular visits from a fitness professional had ceased during the COVID-19 pandemic. However, they showed us emails confirming that these were due to recommence during the week after our visit. Staff encouraged people to go for walks in the garden or within the local community.

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 with appropriate legal authority. 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.

● People's care plans included information about their capacity to make decisions about their care and support. DoLS authorisations had been sought for people where there were risks in relation to their capacity and safety. People were supported by staff who had received MCA/DoLS training and understood their

responsibilities around ensuring consent.

● Staff members told us that they always asked for people's agreement before supporting them with personal care and other tasks. We observed staff members seeking consent from people when offering care and support. A person said, "Oh yes, they always ask what I want and do it the way I want it."

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

- There was a friendly, welcoming atmosphere. People told us staff were kind and treated them well. Staff were respectful to people and provided them with assistance in a friendly and caring manner. People spoke positively about the staff and the support they received. A person said, "The staff are all fine. When I am awake at night, the night staff are especially good at making sure I am OK." Another person said, "The staff are lovely". However, although we received positive feedback from one relative, another family told us, "I don't think they fully understand my [relative]'s needs".
- People's diversity needs were recognised and supported by the service. People's personal relationships, beliefs, likes and wishes were recorded in their care plans. People's cultural choices were respected. People who practiced a religious faith had been supported to do so in the past. However, the provider told us visits by faith representatives had been curtailed during the COVID-19 pandemic and had not yet recommenced.

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

- People told us that they made everyday decisions and choices including when they wanted to get up, what to eat and what they wanted to wear. One person said, "Although I would prefer to be in my own house, I can do everything I can do here. The staff help me with this."
- Resident's meetings took place where people were consulted about changes to the home, menus and activities. The notes of these meetings showed that people had been consulted about changes in relation to COVID-19. During our inspection a community nurse visited to provide people with COVID-19 'booster' vaccinations. This had been discussed with people at a resident's meeting.

Respecting and promoting people's privacy, dignity and independence

- People told us that staff were respectful of their privacy. Staff supported people with their personal care in a manner that maintained their privacy and dignity. A person said, "When I need help, they don't make a big thing about it. I feel I have the privacy I need,"
- People's independence was supported. People told us that they were encouraged to be independent and to ask for help if required. A person told us they were able to go to local shops independently. Another person said, "They give me time to get up and go." We observed staff encouraging people to do as much as they could for themselves. For example, a person being supported to eat a meal was encouraged and enabled to use their cutlery to eat independently.
- People's private and personal information was stored securely, and staff understood the importance of confidentiality.

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 Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant people's needs were not always met.

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

- People's care records contained care plans and risk assessments. However, we found the care plans and risk assessments had not always been updated to ensure they were personalised and included detailed up to date information about their individual needs, abilities and preferences. For example, the care plan and risk assessment for a person who had left the home un-noticed had not been updated to reflect the risk of harm to the person. COVID-19 risk assessments for people were identical and did not reflect individual risk.
- Although people's care plans and risk assessments contained guidance for staff on providing support to people, we saw this was not always followed. For example, the choking risk guidance was not followed by staff during a mealtime we observed.
- People's care records had not always been updated to include outcomes of health appointments.

The above is evidence of a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff demonstrated knowledge about people's individual needs and how to provide them with the care and support that they needed and wanted.

End of life care and support

- Records about people's end of life wishes and preferences varied. The provider told us that some people and family members were not always willing to discuss this. However, the provider had not maintained records showing discussions had taken place with people or family members regarding end of life wishes and preferences.

The above is evidence of a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider said that people would be supported to remain at the service at the end of life if they so wished, in familiar surroundings, supported by their family and staff who knew them well.
- The provider told us that people had been supported to spend their last days at the home in the past. They described how healthcare professionals including GPs, district nurses and palliative care nurses had provided the service with guidance and support when people were being supported at the end of life. Some staff members had received end of life care training provided by local palliative care team professionals.

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

● People told us that friends and family members were welcome to visit them at the home. A family member said, "I visit regularly but now I have to take a test when I visit which I am happy to do."

● We did not see activities with people taking place during this inspection. However, one person went out to shop and we saw two people using the garden. The provider told us activities had been reduced during the COVID-19 pandemic. However, they showed us a room they were planning to use for activities and an email confirming the re-commencement of seated physical activity sessions during the week following our inspection. The provider told us staff supported people to undertake activities at the home, but this was not evident from our observations nor any activity records.

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 home had a policy on the AIS. Information about people's communication needs was included in their care plans. The provider told us that, although no-one currently living at the home required information in an accessible format or language, they would ensure accessible information was provided to people in the future should they require these.

● Some information was provided in easy to read formats. This included the provider's complaints procedure. Information about the menu of the day was displayed on a large notice board in the dining room. A board in the lounge area displayed the date and day to assist people with orientation about time. However, these were not updated until later during the days of our inspection. The provider said that staff would always explain any information that people did not understand. People confirmed that staff supported them with information.

Improving care quality in response to complaints or concerns

● The service had a complaints policy and procedure. People knew how to make a complaint. One person told us, "I tell them if I am not happy with anything and they sort it out for me straight away". However, one family member said, "I'm not convinced the provider listen's to complaints."

● Care staff knew that they needed to report any complaints about the service that were brought to their attention by people using the service, people's relatives or others.

● We looked at the home's complaints log and saw that there had been no formal complaints recorded since our last inspection.

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 Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
At our last inspection we found failures in the provider's quality assurance and monitoring systems. Policies and procedures in relation to COVID-19 were out of date up-to-date government guidance had not been followed. Fire safety and environmental risks had not been identified or safely managed. The provider had not made arrangements to ensure that weekly safety checks were regularly carried out. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had made some improvements. However, we found further failures in the provider's quality assurance systems.

● We found the provider's records of COVID-19 testing were incomplete and we were unable to tell if people and staff had been tested regularly. This meant there was a risk to people of contracting COVID-19. Temperature checks of people, staff and visitors were shown to give consistently low temperatures. The provider's monitoring had not identified these concerns.
● We found gaps around fire doors at the home. The provider had failed to follow a requirement made in an independent fire risk assessment stating that an assessment of all fire doors at the home was made.
● We found cracked tiles and exposed grouting in bathrooms. We had identified this as an infection control risk at our last inspection, but this had not been addressed. Following this inspection, the provider sent evidence that remedial works had been carried out.
● The provider's weekly hot water temperature monitoring had failed to identify that hot water temperatures were consistently low. Details are contained within the safe section of this report.
● We found out-of-date food in the home's fridge. There was no system for ensuring staff checked sates of chilled food items and removed these to ensure there was no risk of people eating food past its use by date.
● People's care plans and risk assessments had not always been updated to reflect their current needs. The provider's monthly reviews of care records had failed to identify this.
●We were not assured that the provider had a sufficiently robust quality assurance and governance system in place to identify arising issues and problems and put them right.

The above is evidence of a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had made arrangements to ensure regular weekly quality and safety monitoring now took place.

● The provider had updated their COVID-19 policies and procedures. We saw that changes had been with staff members at their regular monthly meetings.
● The provider had improved fire signage and a lock to an external fire exit following our previous inspection of the home.

Working in partnership with others
● People had been supported to attend regular appointments and health professionals had visited the home where required. However, outcomes of appointments had not always been recorded. For example, the provider told us that a person who was identified as 'shaking' had been seen by a GP who advised this was due to their age. However, there was no record of this in their care records.
● The provider told us she had regular contact with the local authority and had attended on-line meetings set up for care home providers.
Continuous learning and improving care
● The provider had not acted immediately to ensure actions in relation to fire doors were addressed following a fire risk assessment.

The above is further evidence of a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider and staff had participated in learning opportunities provided by the local authority throughout the COVID-19 pandemic, including training in relation to infection prevention and control.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Staff members spoke positively about their roles in delivering quality person-centred care.
● People told us staff were responsive. A person said, "Some staff are better than others, but they always make sure I am fine." We had mixed feedback from the family members we spoke with. One said, "[Relative] is very happy there. I think they look after [relative] very well." However, another family member said, "It's got a bit better, but I don't think they fully understand [relative's] needs."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider had notified CQC of incidents and concerns required in relation to the home's registration.
● The provider described the importance of ensuring that people, family members and other key professionals were always informed when there were any issues or concerns. However, a local authority representative advised us that a recent incident had not been reported promptly.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Regular monthly meetings had taken place for people living at the home. The records of these meetings showed that people were asked for their views about, for example, changes at the home, activities and meals. Staff had discussed COVID-19 testing and vaccination with people at these meetings.
● Details about people's information and communication needs were included in their care plans. Staff understood how to provide people with the information they required. For example, a person with a visual impairment received information verbally and on tape.
● Staff team meetings had also taken place regularly. The records of these showed that staff were provided with opportunities to discuss people's care and support needs and preferences. Information about COVID-19. Staff were advised changes to the home's COVID-19 policies and procedures at these meetings.

● A family member told us, "I visit regularly and the staff tell me if there is anything I need to know about [relative]". However, another relative said, "I'm not sure they will tell us if there is a problem."