St. Cloud Care Limited

Chestnut View Care 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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Chestnut View is a care home providing nursing and personal care for a maximum of 60 older people, some of whom may be living with dementia and/or a physical disability. The home accommodated people across three floors, one of which was for people with nursing care needs and one of which specialised in providing care to people living with dementia. At the time of our inspection the service was providing care to 36 people.

People's experience of using this service and what we found.
There were not always enough staff deployed at the service which left people at risk. Risks associated with people's care were not always being managed in a safe way, including people's nutrition and hydration and cleanliness of the service. Incidents and accidents were not always followed up on to avoid the risk of reoccurrence.

People did not always have choices around their care delivery and at times were not treated with dignity and respect. People were at risk of social isolation and opportunities to take part in activities were at times limited. Although people and relatives knew how to complain, they did not always feel listened to. Complaints were not always investigated fully.

Quality assurance was not always effective. Where shortfalls in care had been identified with staff this had not been addressed robustly. The leadership needed to be more effective in ensuring staff were delivering appropriate care. The provider had failed to maintain robust oversight of the service. As a result, the level of care had deteriorated from the last inspection.

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. People had access to healthcare professionals to support them with their care. People and relatives told us that staff were kind and caring and we did see examples of this.

Rating at last inspection (and update)
The last rating for this service was Requires Improvement (published 25 June 2019) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had not been made and the provider remained in breach of regulations. The overall rating for the service had deteriorated from Requires Improvement to Inadequate.

Why we inspected
This was a planned inspection based on the previous rating.
We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the

service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the Safe, Effective, Caring, Responsive, and Well Led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

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

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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to risks related to staffing levels, safe care being provided to people, people being at risk of social isolation, lack of activities, people being supported with adequate nutrition and hydration, and the lack of robust provider and management quality assurance at this inspection.

For requirement actions of enforcement which we are able to publish at the time of the report being published. Please see the action we have told the provider to take at the end of this report.

Follow up
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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our safe findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our safe findings below.

Is the service responsive?

Requires Improvement

The service was not responsive.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our safe findings below.

Chestnut View Care 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.

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

Inspection team
Our inspection was completed by three inspectors.

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

The service did not have a manager registered with the Care Quality Commission. This means the Provider 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 reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. 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 also spoke with one relative.

During the inspection-
We spoke with nine people who used the service about their experience of the care provided. We also observed care and interaction between people and staff. We spoke with 13 members of staff including the regional manager, nursing staff, activity staff, catering staff and care staff.

We reviewed a range of records including multiple medication records, safeguarding records and complaints. We reviewed a variety of records relating to the management of the service including three staff recruitment files and audits of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, policies, audits and six people's care records. We spoke the deputy manager and received feedback from five relatives.

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 deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

At our last inspection of the service, we found the provider had not ensured there were sufficient staff deployed at the service to provide safe care to people. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had not been made at this inspection and the provider remained in breach of regulation 18.

Staffing and recruitment

- People we spoke with told us there were not enough staff to support them. Comments included, "You can bang about and hope someone will come", "Some days I can get help, but some days you can't get anyone" and, "I use the call bell when I am in bed and want somebody, they are not quick with help though."
- There was a shortage of staff on shift to support people, putting them at risk of harm. During the morning, on the dementia floor, we observed four of the six people who lived on the unit (who staff told us were at risk of falls) sitting in a lounge. There was only one member of staff allocated to the unit who was busy supporting another person in their room. Whilst the member of staff would pop in quickly to acknowledge people, they went off again to support the person in their room and to do other duties on the floor, including making beds and getting drinks.
- The member of staff advised us one person had fallen that morning which took around 40 minutes to manage. They told us this meant all the other people had been left unsupported. The member of staff said, "Most people will try and get up. Ideally I would like to have two of us."
- We also observed staff on the remaining units were busy and had little time to check on people being cared for in their rooms. One person on the top floor told us, "There's no-one here. I wait and wait." On the morning of the inspection we observed a cleaner sat with two people (who staff confirmed were at risk of falls) in the lounge on the top floor. The member of staff told us, "I saw them by themselves I wanted to keep an eye on them. It is my moral duty."
- We noted from incident records there had been 24 recorded unwitnessed falls at the service between January 2021 and 31 May 2021. Although the majority of the falls did not result in an injury, the provider had not considered whether this pattern indicated a need to review the current staff deployment plans. increasing staff numbers to reduce the risk of falls to people. One member of staff told us, "There are not enough staff. The biggest impact is on the nursing floor. Although we have sensor mats there was an increase in falls." After the inspection the deputy manager told us, "It would be ideal to have another nurse and carer."
- The dependency tool used to determine staff levels did not always reflect the risks to people to determine what the minimum safe staffing deployment should be. For example, one person had four unwitnessed falls this year and yet the dependency tool stated they were only at 'medium' risk. Another person had three unwitnessed falls, yet the dependency tool did not reflect this. After the last inspection where we raised

concerns about staffing levels, the provider sent an action plan that stated, "Management team to continue walk round the home daily at different times of the day. Observing staff interaction and the appropriate deployment of staff in the different areas of the Home." We found insufficient evidence this was taking place.

● Staff fed back there were not sufficient staff on shift each day. Comments included, "There is not enough staff, the impact is people don't get out of bed. People are being neglected" and "It's just not enough. When there's only two of them, it's difficult to attend to everyone."
● In addition to the lack of care staff, there were not sufficient nursing staff on duty on the day of the inspection. The nurse on duty was also responsible for the home whilst the manager was absent. We observed that while they were administering medicines, they were called away from the top floor to the middle floor to deal with an emergency. This meant that medicine administration was delayed. A member of staff said, "One nurse isn't enough, there used to be two nurses. The nurse cannot be everywhere, they have to help on the top floor, and we can't always get to her."
● After the inspection the deputy manager told us, "I have raised this a lot (one nurse being on duty)." They told us they were also a nurse but that managing the service and supporting the nursing staff was a struggle. They said, "If you want care plans done and If you want accidents adequately attended to then you need a trained eye. If I am called to a meeting, then this leaves the nurse on their own."

Failure to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff was a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider operated effective and safe recruitment practices when employing new staff. This included requesting and receiving references and checks with the Disclosure and Barring Service (DBS). DBS checks are carried out to confirm whether prospective new staff had a criminal record or were barred from working with people. We saw that nurses' professional registration was in date.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong; Preventing and controlling
● Risks associated with people's care was not always managed in a safe way. There were people at the service that had the capacity to use call bells to alert staff. However, on the day of the inspection we found they were often out of reach. On the morning of the inspection a person called out to us in distress as they had dropped a drink down their clothing and needed help to change. The person's call bell was out of reach, so we used the call bell in the communal bathroom to summon assistance for them. Although we managed to find a member of staff to assist the person the call bell in the bathroom continued to ring for over an hour.

● Staff told us that one person had behaviours of verbal aggression that often impacted another person on the same unit. We found this was not being appropriately managed which left people at risk. One member of staff told us, "(Person 1) finds (Person 2) very difficult. It's verbal not physical but this can upset (Person 2)." Although ABC charts for monitoring behaviours were used on occasion, this was not consistent. The member of staff told us, "We can do behaviour ABC charts, but it's considered normal." They told us they did not routinely record the behaviours. Person 1's care plan stated, "Try not to have (Person 1) and (Person 2) on the same table during mealtimes as there has been a history of misunderstandings between the two ladies." However, we noted in the morning they were sat at the table together with no staff present because they were busy elsewhere.
● The deputy manager told us they discussed incidents and accidents at clinical meetings each week but acknowledged that more could be done to analyse them for trends and themes. They told us the provider's quality team would audit the incidents at the service. However, there was no evidence of what action the

provider had taken to manage the risks around incidents and accidents including the frequent unwitnessed falls and management of behaviours which may challenge others.
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. We found the general cleanliness required improvement. For example, people's bedrooms doors and bathrooms were dirty. In three people's rooms the carpets smelled strongly of urine and another person's commode was stained. In another person's room there was stained underwear hanging in their bathroom. One person's wheelchair frame had build-up of dirt around the frame. The jugs of water provided in people's rooms had not been cleaned appropriately. There were sticker marks left on there from previous days.
● On the day of the inspection there was only one cleaner rostered to work across all three floors. The cleaner's day was also interrupted when we saw them sat with people on the nursing floor to support care staff to prevent the risk of the people falling. One member of staff said, "There are not enough cleaners at all. I would say the place is dirty."

The failure to manage risks associated with people's care in a safe way was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Where clinical risks were identified, appropriate management plans were developed to reduce the likelihood of them occurring, including around wound care, diabetes care and other healthcare concerns. Where wounds had been identified, regular photographs were taken of the wound to track the progress.
● There were Personal Emergency Evacuation Plans (PEEPS) in place for people with details around how they needed to be supported in the event of an emergency. There was a Business continuity plan that detailed what staff needed to do in the event of an emergency such as a flood or a fire.
● We assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● 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.

Using medicines safely
● There were appropriate systems in place to ensure the safe storage and administration of medicines. People's medicines were recorded in their medicines administration records (MARs) with a dated picture of the person and details of allergies, and other appropriate information, for example if the person had swallowing difficulties.
● There were medicines prescribed on an 'as required' (PRN) basis and these had protocols for their use. We saw that staff checked people's blood sugar levels where the person had diabetes.
●Medicines audit were undertaken regularly, and all the nurses had been competency assessed to ensure that they had the skills required to administer medicines.
● We raised with the regional manager that only one signature was present for the accounting of medicines when they came into the service. The regional manager told us there should have been two and said they would ensure this was addressed in the future.

Systems and processes to safeguard people from the risk of abuse

● People told us that they felt safe with staff. One said, "I'm alright. I think it's safe. The carers are lovely." Another said, "They're nice. They're kind. They will help me."
● Staff understood what constituted abuse and the actions to take if they suspected anything. One told us, "I would report to the nurse or the manager."
● Staff received safeguarding training and discussed any potential safeguarding incidents during team meetings.
● We saw that, where there were any concerns raised, the manager would refer this to the local authority and undertake a full investigation.

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.

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

● In March 2021 six people living with dementia had been temporarily moved to another part of the service. This was whilst improvements were being made to the floor they had been living on. The unit they were currently living on was not a dementia friendly environment. People's bedrooms doors were not all differentiated in colour and there were no memory boxes or clear signage to help orientate people to their rooms or to other parts of the unit. One member of staff told us, "The environment needs looking at. It's hugely not dementia friendly." The provider's dementia policy stated, "Any design and structure regarding the layout of the environment will be based on recommendations and best practice." The policy included ensuring there was appropriate signage, meaningful spaces and to enable orientation. The provider was not following their own policy around this.

● There were no sensory items or areas of interest for people on the temporary dementia unit, particularly for those who walked with purpose. The living room was small and was also used as the dining room and there was little space for people to move around. A member of staff told us, "It's just blank walls. I have raised it." Another member of staff said, "They could have brightened the area up and there are no curtains in the lounge. I did raise that." The corridors were dark and there was low lighting. This was despite one person's care plan stating, "Use the corridor lighting to ensure there's good visibility throughout the unit."

As the premises was not always be fit for purpose in line with statutory requirements and taking account of national best practice this was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● There were mixed responses from people about the food and drink. Comments included, "The food is alright", "It's quite nice", "Lovely food' and, "Almost inedible food." One relative told us, "(Person) always complains about the lack of fresh things."

● People's hydration needs were not always being managed in a safe way which put them at risk. According to their care plan, one person's, "Fluids also need to be encouraged". The person was placed on a fluid chart where it was recorded that staff should try and ensure they had 1500 millilitres (mls) each day. However, their chart recorded that frequently they were drinking far below this. On nine occasions over a six-week period, the person was recorded to have had less than 200mls in a day. The person's daily care notes recorded on one day the person (who according to their care plan required support to drink) was only offered a drink on two occasions. Older people are at increased risk of dehydration, which has potentially serious health consequences.

● We reviewed the care notes for all people living at the service over a 45-day period and saw six people had suffered with a urinal tract infection (UTI) which can be triggered when people have not been sufficiently hydrated. One relative told us, "That's a big issue. I have raised it many, many, many times, because mum gets urine infections. They don't always have a drink beside them."
● People were at risk of not receiving adequate nutrition. There were people at the service who had been assessed to be at high risk of malnutrition. One person's nutritional assessment stated they had lost weight in the last few months however their weight was now stable. Their care plan indicated they needed encouragement to eat and needed their weight monitoring weekly. It stated they should to be offered a high protein diet and to offer smoothies twice daily and offer snacks. We noted from their care notes they were offered their main meal but there was no record of them being offered smoothies or other snacks. Another person had lost three kilograms of weight in one week and there was conflicting information about whether they were at medium or high risk of malnutrition. The person's care notes stated they often refused their main meal. The was no record of the person being offered snacks or food outside of the usual mealtime.
● We saw staff encouraging people to drink and people did have drinks beside them in their rooms. However, although there were drink stations around the service these were not always accessible for people. The large water jugs were too heavy for people to help themselves and there was no drink station on the ground floor lounge/dining room where people were sitting. One person told us, "If I ask, I can get clean water (for drink), but staff do not always have time and sometimes I drink two-days-old water which is warm."
● On the day of the inspection people were not offered snacks during the morning due to there being a shortage of kitchen staff first thing in the morning.
● The chef had information in the kitchen about people's dietary needs however this was not always kept up to date. The chef told us, "'I have not been told currently of anyone at high risk of malnutrition." However, there were people that were at high risk of malnutrition and required fortified meals and snacks.

As there was a risk that people were not supported to eat and drink enough to maintain a balanced diet this was a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection of the service, we found the provider had not ensured that appropriate decision-specific capacity assessments had taken place for people. This was a breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Sufficient improvement had been made at this inspection and the provider was no longer in breach of regulation 11.

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.

● Relatives fed back they were consulted in relation to their family members' care. One told us, "They do

approach me." Capacity assessments had been completed where people were unable to make decisions for themselves. These assessments were specific to particular decisions that needed to be made for example in relation to bed rails, sensor mats and locked doors. Records showed that staff ensured family members were involved when a best interest decision was made on the person's behalf about their care and support.

● DoLS applications had been completed and submitted in line with current legislation to the local authority for people living at the service where it was required. People who were not subject to a DoLS were not restricted in any way.

● Staff received training around MCA and DoLS and understood the principles involved. Where staff had a concern about the capacity of a person, they raised this with their line manager.

Staff support: induction, training, skills and experience

● Staff completed a full induction when they first joined the service. This included completing all the mandatory training and then shadowing experienced care staff. One member of staff said, "Training is good. I had it all before I arrived (worked their first day)."

● Clinical staff told us that they had regular training to refresh their skills and we saw that additional training had been organised. All other staff were also updated with training specific to their roles.

● Care staff had received appropriate support that promoted their professional development and assessed their competencies. The clinical lead undertook one to one and group supervisions with nurses on a regular basis and other staff met with their line manager regularly.

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

● Care and support was planned in line with current evidence-based guidance. The service standards incorporated relevant guidance that was specific to the services they delivered. For example, from the National Institute for Health and Care Excellence, Mental Capacity Act 2005 (MCA) and NHS England.

● Information about people's needs had been assessed before they moved in. This was to ensure that the provider knew the service could meet their needs. Assessments included information about communication, allergies, medical background, weight, dietary needs, mobility, memory and cognition.

● Staff worked with healthcare professionals in support of people's care. We saw evidence of involvement from the GP, tissue viability nurse (TVN), physiotherapist and nutritionist. A relative told us, "They (their family member) have regular check-ups with the doctor." Another said, "She had an eye test the other day. I've now ordered her some glasses." The deputy manager told us, "I think I have a good rapport with the surgery, I do the doctor's round. I think the relationship is very good."

Requires Improvement

Is the service caring?

Our findings

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

At 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 did not always feel well-supported, cared for or treated with dignity and respect.

Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence; Ensuring people are well treated and supported; respecting equality and diversity

- People fed back to us that staff were caring. Comments included, "They're all grand here", "We get on quite well", "Staff are excellent" and, "They are lovely here." One relative said, "The carers are very kind." Another said, "Mum's very happy and they're very caring."
- Despite these comments, staff were very busy at the service which left little time for them to have a lot of meaningful interactions with people. For example, we saw that one person in their room had very little contact with staff throughout the day as staff were busy elsewhere. This left the person at high risk of social isolation.
- People's wishes were not always respected. Although care plans showed that people were asked about their preferences around their care, this was not always supported by staff. For example, in one person's care plan it stated that they preferred to get up early before breakfast. However, on the day of the inspection the person was not supported to get up until lunch time. One member of staff told us this was normal practice to not get the person up before lunch due to their risk of falls and there not being enough staff to monitor them. Another member of staff said, "[Person] stays in bed until after lunch. She's got delirium. She tries to walk when she's in her chair." This practice was driven by staff convenience and mitigating risks due to low staffing levels rather than supporting the person's preferences.
- Another person fed back that they were only offered a hot drink in the morning and not in the afternoon. They told us, "One coffee a day is all I get." We also saw that people who were on a pureed diet were not always offered a choice of meal.
- People were not always given the choice of bath and showers and instead were provided with a body wash. One person told us, "You can have a bath when they have time, used to be Mondays but varies depending on staff." Staff told us that baths and showers were on a rostered basis.
- One person's care plan stated that they should be offered a bath or shower daily and enjoyed having their hair washed regularly. A member of staff said, "We do a schedule around baths and showers. Every day one resident will have a shower." They said that people would not have a choice to have one every day. We reviewed the daily care notes for people at the service. Over a 45-day period, in total only 11 showers and seven baths had been provided to people. There was nothing in the records to suggest that people were frequently refusing baths and showers.
- Prior to the inspection a relative made us aware about the thick skin that had developed on their family member's feet due to them not being washed appropriately at the service. The regional manager told us this had been raised with the local authority as a safeguarding concern.

● People's oral health care was not always being managed which was not dignified for people. We noted on one unit in the morning that people's toothbrushes were dry despite them having had their personal care. A member of staff told us, "Oral care isn't happening as often as it should."

As people were not always treated with dignity and respect and were not always given choices around their delivery of care this was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● During the inspection, when staff did interact with people this was done in a caring way. When supporting a person in bed they were heard to be supportive and encouraging. The member of staff was heard to say, "Maybe you could eat the whole thing this time, lovely, glad you like it." On another occasion staff were seen to be laughing and joking with a person, the member of staff took an interest in the person's activity they were doing in their room.
● When staff entered people's rooms, they knocked and waited for a response. They also ensured the doors were closed when attending to personal care. One person told us, "They (staff) are very polite and respectful."
● People were able to personalise their room with their own furniture and personal items that were important to them.

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.

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 were not always supported with meaningful activities. During the morning of the inspection the people on the dementia unit had no opportunities to take part in activities. People were sat in the lounge area with little or no meaningful interaction. People's care plans we reviewed indicated that people enjoyed activities and should be supported to partake in activities of interest, but this was not taking place. A member of staff said, "The activities are not always dementia-friendly." Another said, "There should be more activities. We could interact with people more."
- On the other floors at the service there were also no activities taking place in the morning. A member of staff told us that there were no planned activities for people on the day of the inspection. This was due to the activity coordinator needing to support two people to have their vaccination. However, during the morning of the inspection, a member of staff had been called in from annual leave to support with activities. When we left the inspection later in the afternoon, we saw there were people gathered in one of the activity lounges for an activity that was about to take place.
- In addition to group activities, staff were to provide one to one activity to people particularly for those cared for in their room. We noted from the May 2021 activity notes that, out of 36 people, only 10 incidents of one to one activities were recorded as taking place.

Failure to ensure people are people supported to follow their interests and take part in activities that are socially and culturally relevant and appropriate to them was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Improving care quality in response to complaints or concerns

- One person told us they would not hesitate to raise a complaint saying, "I would definitely say something." There was a mixed response from relatives about whether they felt their complaint would be addressed. One told us, "They listen but then you go in a few days later and no drinks. It's something so simple and it's not done." Another said, "Depends on concern. In terms of concerns around care they do."
- Complaints and concerns were not always used as an opportunity to improve the service. We were aware of one complaint in early June 2021 from a relative who had concerns their family member was not having a bath or shower regularly. However, we found the same concerns when we inspected.
- Prior to the inspection we were made aware of four complaints that had been made by family members relating to aspects of the care delivery. However, when we reviewed the complaints folder provided to us there was only one complaint in there, which related to a different concern. We were unable to identify what actions, if any, had been taken to resolve the other complaints we had been made aware of.
- The service complaints policy stated, "A full record will be held of all complaints regardless of the level of

seriousness and means of communication." However, the provider was not following their policy in relation to this.

As complaints and concerns were not always investigated and appropriate action taken this was a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Care plans outlined individuals' care and support including personal hygiene, medicine, health, sleep patterns, emotional and behavioural issues and mobility. The care plans also contained detailed information about people's care needs and actions required in order to provide safe and effective care. Any changes to people's care were updated in their care records to ensure that staff had up to date information.
● Where people had diabetes there was information available to all staff about the management of where their blood sugar levels were too high or too low. Nursing staff were knowledgeable about people's clinical needs and there was clear information on the support they were providing, for example in relation to catheter care, wounds and diabetes.
● End of life care was provided in a dignified and respectful way. More information was required in the care plans around the discussions with people and their loved ones. The care plans we reviewed contained information on whether people wanted to be resuscitated and that they may want to remain the at the service. However there lacked detail around people's wishes nearing the end of their life. This is an area that requires further development and improvement.
● Care plans had records in place which detailed how the person was able to communicate. Examples included whether the person was able to verbally communicate. One care plan stated the person did not like wearing hearing aids and staff they were facing the person when they spoke with them. We observed staff communicating with the person in this way.

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 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.

At our last inspection of the service, we found the provider had not ensured there was ongoing and robust management oversight was needed to ensure changes and standards were maintained. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had not been made at this inspection and the provider remained in breach of regulation 17.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Since the last inspection there had been a recruitment of a registered manager. However, they left the service in January 2021 and a new manager was due to start in July 2021. This left the deputy manager temporarily managing the service with support from the provider's regional team whilst they recruited to a new manager. This was having an impact on the leadership and oversight of care.
- People and relatives we spoke with about the deputy manager praised them. One person said, "She is a lovely lady." A relative told us, "I have confidence in (the deputy manager). She's very good and very honest."
- Staff were highly complementary of the deputy manager's support. Comments included, "(Deputy manager) has done a tremendous amount. She has always been good to me", "(Deputy manager) is excellent but overworked", and, "Her door is always open, and you can talk to her." However, in addition to managing the service, the deputy manager was also providing clinical support as the second nurse on duty. This impacted on their ability to have robust oversight of the quality of care. One member of staff said, "We just need to be stable really. When you have a manager and the manager goes, it's just unstable and unsettling." The deputy manager told us, "I'm conscious I need to be here there and everywhere."
- We found shortfalls during the inspection that had not been identified through provider visits to the service. The provider had also not always acted feedback from complaints, staff and previous CQC findings. A representative of the provider told us they and others visited the service two or three times a month. However, they had not identified the concern around staff levels and this impacting on the care delivery including people not having sufficient baths and showers.
- The audits that took place were not robust in identifying shortfalls. For example, a call bell audit took place in June 2021 which stated that staff response to calls bells could be delayed at night. However, there was no system check to see how long people's call bells were being taken to answer. There was also no action plan in place to address the delay to calls at night.
- An infection control audit on 2 June 2021 stated that curtains were needed for the dementia unit. This had still not been addressed on the day of the inspection. It also stated that the flooring in people's rooms was,

"Free from visible stains." We found this was not the case and it had not been identified that two people's bedroom carpets smelled strongly of urine

● Insufficient action was taken by the provider when they were aware of staff absence in advance. For example, there was no team leader on the top floor and only one cleaner on the day of the inspection due to planned absence. The provider had not planned for this absence to ensure that additional staff were rostered on to work.

● Where food and fluid charts for people were completed, these were not always audited to identify any inaccuracies or concerns. When we compared the fluid charts for people these did not always match the daily records that staff completed when they offered a person a drink. For example, one fluid chart stated the person had drunk 200mls in one day however their daily notes indicated the person had drunk 300mls.

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

● Staff told us they had been emotionally impacted during the Covid-19 pandemic whilst working at the service. They told us they did not feel the provider had supported them through this. One member of staff said, "The providers don't listen enough. Staff went above and beyond during Covid."

● Staff told us they did not feel valued by the provider. They felt their views were not always being considered when staff levels were being reviewed. One told us, "It's emotional stress when you need to rush to help people, not only physical stress on staff." Another told us, "I love the job, but I'm shattered", whilst another said, "I dread it (coming to work due to the staffing levels)." Staff told us that at times there were unable to take their break due to staff levels.

● Residents' meetings were taking place and people were updated on the visiting restrictions, menus and activities. However, there was no evidence that people were asked for their feedback in relation to staff levels and the quality of care. Staff meetings also addressed areas for development but there was no record on the minutes that staff were asked for their feedback on staff levels or anything that might impact their roles.

As systems or processes were not established and operated effectively to ensure compliance with the requirements this was a repeated breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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; Working in partnership with others

● Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The provider had informed the CQC of significant events including incidents and safeguarding concerns.

● The provider and staff worked with external organisations that regularly supported the service. This included the local authority and healthcare professionals.

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 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured that people always received person-centred care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had not ensured that people were always treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider had not ensured that people's nutritional and hydration needs were always being met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had not always ensured that the premises was set up to suit the needs of people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had not ensured that complaints were not always investigated and responded to

appropriately.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider had not ensured that people always received safe care and treatment.

The enforcement action we took:

We issued a warning notice in relation to this breach.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider had not ensured there was robust leadership and oversight of the service.

The enforcement action we took:

We issued a warning notice in relation to this breach.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Treatment of disease, disorder or injury	The provider had not ensured there was appropriate staff deployed at the service.

The enforcement action we took:

We issued a warning notice in relation to this breach.