Cheriton (Amersham) Ltd

Cheriton Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
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
Cheriton Care Home is a residential care home registered to provide care for up to 27 people. It was providing personal care to 19 older people and people with dementia aged 65 and over at the time of the inspection.

People's experience of using this service and what we found
People did not receive safe care. Staff did not consistently follow good hygiene practices at the home, to prevent the spread of infection. For example, staff did not always wear face masks to keep their nose and mouth covered. Beds had been made with linen which was stained; in one case a valance was wet from urine. The risks of contamination and spread of infection had not been recognised, from the practices we observed.

Risks to people's health and safety had not been adequately assessed and measures put in place to prevent avoidable harm. For example, people could easily open an upstairs fire exit door which led onto the fire escape steps. The provider was aware someone was known to tamper with this door but had not taken action to mitigate the risk of people being able to get onto the fire escape and try to get down the steps. There was a risk people could fall and suffer extensive injury.

Staff did not respond when someone was coughing whilst eating their lunch. There was no recognition the person may need some assistance or checking to see if they were alright. We were concerned staff were not alert to the risk of people choking. In another example, a person's care plan had not been updated with guidance from a speech and language therapist regarding the correct texture of food and drink they required. There was a risk the person could be served with food and drink they could not safely swallow.

People lived in a building which had not always been maintained to a safe and comfortable standard. For example, a door closure was broken and had been taped together to keep it in place. We found a strip to seal a bedroom door in the event of a fire had come away. The provider was not aware of these and other maintenance issues we found. Staff were aware in February this year one person's television was not working. Whilst we were at the home on the second day of the inspection, we saw the television was still not working and the person asked us if we could fix it for them.

The provider was unable to provide evidence of learning from accidents and incidents. We have made a recommendation about developing their approach, to prevent incidents recurring.

Improvements had not been made to make the environment more suitable for people with dementia. The premises were worn in places. Bedroom furniture provided by the home was basic and not always in good condition. Memory boxes had been placed outside some bedrooms. The idea of these boxes is for them to contain an item or items which are meaningful in some way to a person with dementia. This could be things such as a wedding photograph or postcard from a holiday destination. None of the boxes had been put to

use.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; how the service implemented the policies and systems did not support this practice. Staff did not fully understand about mental capacity. We found some applications to deprive people of their liberty had been inappropriately made because people they related to did not lack capacity and could make their own decisions. Records of deprivations approved by the local authority were not accessible in the building. This meant staff did not know what restrictions were legally permissible and if any conditions were in place for these.

Staff told us they received training and support. However, we found the provider had not acted on a recommendation we made at the last inspection to carry out probationary assessments before staff were confirmed in post. We were only provided with evidence of one staff meeting taking place in the past six months. We were not assured about the quality of staff training as an induction record showed one member of staff had completed 11 training topics on one day. We have made a recommendation regarding developing staff and promoting good practice.

There was a detailed assessment format for identifying and recording people's care needs. However, some important sections were left blank such as moving and handling and medical history. Good practice guidance was not being followed on recording the needs of people with diabetes. Care plans were not always focused on the full needs of the person or written specifically for their circumstance. For example, some information about medical conditions was generalised and did provide details of any symptoms the person experienced. We have made a recommendation regarding end of life care.

People were not always treated in a way which promoted their dignity. Interactions by staff were task-based rather than focused on the needs of people. There were few activities provided to keep people stimulated.

People were not always offered choices at mealtimes. Staff did not interact with people over lunchtime, just placed food in front of them without speaking. We were not confident dietary needs were being safely managed as there was little understanding about the needs of people with diabetes. Food was cut up for some people without there being a need recorded in their care plans. We have made a recommendation regarding meals and dietary needs.

There were some systems to seek people's feedback but we were not provided with significant evidence of this. Improvements had been made to the complaints procedure, staff recruitment practices and medicines practice since the last inspection.

People spoke positively about the manager. However, in the manager's absence, we found the provider was not aware how the home operated and could not locate records which should be in everyday use. This showed the management structure and processes were ineffective in ensuring people received good quality care. There was a lack of understanding about the requirement to be open and transparent under duty of candour and what was required to provide person-centred care. We have made a recommendation about improving understanding of duty of candour. The provider had not always notified us of events it was required to. The quality of people's care had deteriorated from the previous inspection.

People's feedback about the home was positive. One relative told us "I feel that the staff and management have worked efficiently and effectively during these challenging times, delivering a good quality of care." Another relative said "Overall the care my (family member) receives at Cheriton is very good. The staff and management are kind, cheerful, helpful, welcoming, understanding and respectful to her individual needs."

However, we observed limited interactions between staff, the providers and people living at the home, there was no laughter or light-heartedness around the building and people had little to provide them with interest or stimulation.

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

Rating at last inspection and update
This service was registered with us on 7 May 2021 and this is the first inspection.

The last rating for the service under the previous provider was requires improvement, published on 3 April 2019.

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 the provider remained in breach of regulations.

At our last inspection we recommended the service developed its approach to recruitment of staff, prevention of injuries, improving the environment for people with dementia and assessing staff performance before they are confirmed in post. Further recommendations were made regarding fire practice evacuations, improving care plans for people with diabetes, improving the complaints procedure, developing the approach to the Accessible Information Standard and the duty of candour requirement.

At this inspection we found improvements had only been made to the complaints procedure, fire practice evacuations and recruitment practice.

Why we inspected
This inspection was prompted by a review of the information we held about this service.

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. This included checking the provider was meeting COVID-19 vaccination requirements.

We have found evidence that the provider needs to make improvements. Please see the Safe section of this full report.

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

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

We have identified breaches in relation to providing person-centred care, dignity and respect, notification of incidents, safe care and treatment, good governance, the condition of the premises and safeguarding people from abuse and improper treatment at this inspection.

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

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.

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

Special measures
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 six 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 effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Cheriton 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 Health and Social Care Act 2008.

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

Inspection team
The inspection was carried out by an inspector and an Expert by Experience on the first day. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was care of older people and dementia care. The second day of the inspection was carried out by an inspector and an inspection manager. A further inspector carried out work remotely, contacting staff, relatives and external agencies and reviewing records.

Service and service type
Cheriton Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Cheriton Care Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a manager in post and they had submitted an application to be registered with us.

Notice of inspection
This inspection was unannounced on both days.

What we did before the inspection
We reviewed information we had received and held about the service. 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 (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection
We spoke with 12 people who used the service. We had discussions with the manager and other staff, including the directors and nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We observed part of a medicines round and joined a staff handover meeting. We looked at a range of records. These included five care plans, three staff recruitment files and the staff training matrix. We checked a sample of quality assurance audits and records related to maintenance and upkeep of the premises. We viewed a range of health and safety records. We were restricted in which records we could check during the inspection as the provider could not find many of the files and documents we asked for. This included records about complaints and accident and incident reports.

We contacted 15 staff and 11 relatives by email, to invite them to provide feedback. We received replies from three relatives and seven staff. We also contacted health and social care professionals who support the home.

After the inspection
We sought clarification about some of the evidence we found and reviewed information we asked the manager and provider to send to us after the visit. Not all of the information was provided. We therefore made our assessment on the information we received.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection we recommended the provider and registered manager consult the Health and Safety Executive guidance about health and safety in care homes, to help them understand their responsibilities and what they can do to prevent injuries. At this inspection we found improvements had not been made.

• People were not kept safe and the likelihood of injury or harm had not been reduced.
• Risk assessments had not been put in place for all known risks. For example, one person was known to tamper with an upstairs fire door, removing a bolt which allowed the door to open onto a fire escape. We found the bolt was broken and were able to push the door open onto the fire escape steps. There was a risk people could easily get on to the fire escape and fall down the steps.
• We found an upstairs bedroom window opened fully on to the fire escape. When this was brought to the provider's attention, they told us staff had over-ridden the window restrictor so the room could be ventilated. The person who used the service was in the room at the time. At the last inspection we informed the provider the window could be opened fully and asked them to take action. However, the risks had not been mitigated to prevent the person coming to harm by trying to get down the fire escape steps or falling down them.
• We observed someone coughing as they ate their lunch in the dining room. Staff were present but did not respond to the coughing to check the person was alright. They briefly left the room whilst the person was still coughing. We were concerned staff were not alert to the potential for people to choke whilst eating.
• One person required thickening powder to be added to drinks, to prevent the risk of choking. We read a recent letter from the speech and language therapist which stated three scoops of powder were to be used per 200ml and food needed to be cut up before serving. The care plan contained contradictory information, stating two scoops of thickener were needed per 200 ml and a soft and bite-sized diet was required. There was a risk the person could come to harm from choking, as specialist advice was not being followed.

This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had failed to assess the risks to the health and safety of service users and done all that is reasonably practicable to mitigate any such risks.

• We received conflicting information about whether actions from the fire officer's visit last year had been actioned. The nominated individual told us they were still waiting for a replacement door for the lounge, which did not close properly on its own. However, we were told by a director that all actions had been addressed, although we could see the lounge door had not been replaced. We have referred this to the fire safety officer for their consideration.

At our last inspection we recommended the provider sought advice from a reputable source about carrying out effective fire practice evacuations. At this inspection we found improvements had been made.

• Staff told us there were regular fire drills at the home. We saw these were recorded in the fire log.

• The premises had not consistently been well-maintained. On the first day of the inspection, we found unwanted and excess furniture and equipment was being stored in unused bedrooms rather than being disposed of. The unwanted items had been removed by the time of the second day of inspection.
• Repairs were not carried out in a timely manner. For example, we noticed the cupboard under the sink in the laundry was broken. We noticed it was in poor condition at the previous inspection.
• A television aerial in one bedroom was poorly affixed to the wall and hung down around and over the walls in the room. This looked unattractive and could come loose at any time, causing a trip hazard.
• Aerial and other cables hung down outside by a fire door and along the route of the fire escape. These could become trip hazards during evacuation of the premises.
• We noticed a broken electromagnetic door closure was being held together by tape.
• Several carpets and lino flooring was in poor condition and needed to be replaced to provide a suitable environment for people.
• The edge of a cantilever table in one bedroom was broken and the table needed to be replaced.
• A strip to seal the door in the event of a fire had come away on a bedroom door. There was a risk the door would not prevent the spread of fire or smoke to the safety level required.
• Defects had not been picked up by or reported to the provider by staff. This showed the ineffectiveness of recognising and responding to maintenance issues.
• Minutes of a staff meeting held in February this year showed one person's television was not working. Whilst we were at the home on the second day of the inspection, we saw the television was still not working and the person asked us if we could fix it for them. A message on the screen said there was a problem with the aerial connection. Staff going into the person's room would have seen this message, as we did, but no action had been taken.

This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had failed to ensure all premises and equipment was secure and properly maintained.

• Staff said they received training on moving and handling and use of equipment, to help people reposition safely. One person told us "They use the hoist for me so well, they all know what they are doing as far as I'm concerned." We observed a moving and handling manoeuvre was carried out safely.
• Records were in place to show equipment was serviced, electrical appliances were tested and the gas installation was safe.

Preventing and controlling infection
• We were not assured the provider was using PPE effectively and safely. We saw staff did not consistently position or wear face masks to cover both their nose and mouth.
• We were not assured the provider was promoting safety through the layout and hygiene practices of the premises. We observed several bedroom carpets and some en-suite flooring was stained. On the first day of inspection, packs of incontinence pads were stored on the floor next to toilets, preventing effective cleaning from taking place. These had been removed by the second day of the inspection.
• We observed three people's beds had been made using linen which was stained, rather than changing it for fresh linen. One person's valance was wet from urine. The room was malodorous and had not been kept clean. This showed there were poor standards of hygiene at the home. The person was in their room eating lunch in these conditions.
• We observed the chef changed out of their uniform in the kitchen. This was inappropriate in an area where

food is prepared.
• We were not assured the provider was making sure infection outbreaks could be effectively prevented or managed. For example, we saw a staff member's coat and backpack were stored in the laundry. There was potential for these items to become contaminated and spread infection. We raised this as an issue at the previous inspection.
• We noticed items were being stored in the laundry sink and on the draining board. This also had the potential for contamination and spread of infection around the building.

This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had failed to adequately assess, prevent, detect and control the spread of infection.

• We were assured the provider was preventing visitors from catching and spreading infections.
• We were assured the provider was meeting shielding and social distancing rules.
• We were assured the provider was admitting people safely to the service.
• We were assured the provider was accessing testing for people using the service and staff.
• We were assured the provider's infection prevention and control policy was up to date. However, this was not being followed by staff from the observations we made.

We saw visitors were able to visit their relatives at the home. This aligned with government guidance at the time.

Staffing and recruitment

At our last inspection we recommended the service sought advice from a reputable source about good practice in the recruitment of staff. The provider had made improvements.

• People were protected through safe recruitment practices at the service.
• Staff personnel files contained all required documents, such as written references, proof of identity and Disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
• Staffing rotas were in place to ensure there was sufficient support for people. The provider told us they used agency staff to cover in emergencies but we saw this was not always the case. For example, the chef said they were working seven days a week as there was no-one with the appropriate training to work in the kitchen after a colleague had left.
• People told us "I have a call buzzer and I call them (carer workers) first thing in the morning soon after I wake up. They usually respond within ten or fifteen minutes and that works well for me." Another person told us "Someone could come immediately or I may have to wait ten or twenty minutes. I understand they are busy and might have incidents to deal with but it does get quite hard to wait if you want to go to the toilet." Another person said "I think probably the number of staff is about right. You find some of the staff don't like the job and find it hard and leave quite quickly." A further person told us "I think there are probably a sufficient number of carers here. I get on alright with them, they mostly understand (my needs)."

Using medicines safely

At our last inspection the provider had failed to ensure people's medicines were always handled in a proper and safe way. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12 (1) (g) in respect of medicines practice.

• Staff followed safe practice when they administered people's medicines.
• Staff who administered medicines undertook training and could refer to policies and procedures for guidance.
• The medicines trolley was kept locked when not in use, to prevent unauthorised access to drugs.
• Accurate records were maintained of when medicines had been given to people, to provide a clear audit trail.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to ensure people were safeguarded from abuse and improper treatment, as the home did not have effective systems and processes to protect them. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13 in relation to safeguarding people from abuse.

• People told us they felt safe at the service. Comments included "Yes I am safe," and "I feel safe with all of them now."
• Staff completed safeguarding training. One member of staff told us "I learnt from that training that safeguarding means to protect the person's right to live life safely, without any abuse, harm, fear and neglect."
• There were procedures for staff to follow in the event of any concerns about people's welfare.
• Appropriate referrals were made to the local authority where safeguarding concerns arose.

Learning lessons when things go wrong
• The provider was unable to produce records and other information to show if appropriate action was taken and lessons learned when things go wrong.
• We were only provided with and able to view accident records for March of this year. Two records related to unwitnessed falls. The records were unclear in relation to who took what action and at what time. For example, records relating to one accident stated a controlled drug was given intravenously whilst waiting for medical advice. It was not clear who gave this medicine or when it was given. Another record stated in the lessons learned section the person was to be supervised at all times. There was no reference to an exploration of what may have caused the fall or what could have prevented a reoccurrence.

We recommend the service develops its approach to learning from accidents and incidents, to prevent incidents recurring.

Inadequate

Is the service effective?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's needs had not been fully assessed and records lacked comprehensive information about how they were to be supported.
• One person's care plan had sections to record information about mobility, moving and handling, nutrition, breathing, sleep and daily activities. However, these sections had not been completed. It was therefore unknown what support they required. This could lead to inconsistencies in how staff supported the person.
• In another person's records, 11 of 16 sections on care needs had not been completed. This included moving and handling, mobility, medical history, daily activity and sleep. These examples showed the full range of people's diverse needs had not always been considered, to ensure they receive consistent support.
• At our last inspection, we found the service did not always implement good practice advice from other agencies. For example, in 2016 the local Clinical Commissioning Group circulated guidance to all homes on meeting the needs of people with diabetes. The guidance was forwarded to the home by the inspector after the last inspection. We found the guidance had not been implemented to promote good care for people with diabetes. This meant the home did not make use of guidance to deliver care in line with best practice standards.
• We found care practice did not always promote good quality of life for people. For example, a letter from a healthcare professional recommended one person would benefit from one to one interaction. However, we observed the person was regularly on their own in their room with no input from staff, unless it was to bring meals.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had failed to ensure people received care and treatment which met their needs and reflected their preferences.

• Care and support was enhanced through the use of technology. Sensor mats were in place to alert staff if people moved around, especially at night.
• A relative told us "I feel that the staff and management have worked efficiently and effectively during these challenging times, delivering a good quality of care."

Ensuring consent to care and treatment in line with law and guidance

At our last inspection the provider had failed to ensure information to support people being deprived of their liberty was available to show this was lawful. This was a breach of regulation 13 of the Health and

Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvement had not been made at this inspection and the provider was still in breach of regulation 13 (1) (5).

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, 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 appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

• We found there was a lack of understanding about the provisions of the MCA and when to apply for DoLS. For example, some applications had been made to the local authority inappropriately, as the people had capacity and could make their own decisions.
• One care plan said the person "lacks capacity but can express herself if given the time to express herself" and that they "need time to answer the questions." However, a DoLS was in place which indicated a lack of capacity. It was therefore unclear what decisions the care plan referred to.
• Another care plan contained contradictory information about the person's capacity. Under the sexuality section of the care plan, it stated the person "has a dementia diagnosis, they currently have a DoLS in place". However, the section on mental health said the person "does have capacity and seems to understand where they are and why there are here."
• Records relating to DoLS applications and decisions were not readily available at the home during the inspection; staff and the provider could not produce the records we requested. Some information was sent to us four days after the inspection, some seven days afterwards. Evidence was not provided to show renewal applications had been made where four DoLS had expired.
• We were not provided with any evidence of a DoLS application or best interest decision regarding the use of a sensor mat for one person.
• Lack of accessibility to DoLS and best interest records meant the provider and staff were not routinely aware of any authorised restrictions to people's care and any conditions which may have been imposed to support these restrictions. We could not be assured the service was acting lawfully through practices used at the home.

This was a continued breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the provider had failed to ensure people were only being deprived of their liberty by lawful authority.

Staff support: induction, training, skills and experience

At our last inspection we recommended the service followed good practice in assessing staff performance

before they are confirmed in post. At this inspection we found improvements had not been made.

• We requested evidence of probationary assessments for any new staff at the service. Staff files viewed did not contain evidence to demonstrate staff had successfully completed their probationary period. There was no system to show staff had been assessed to ensure they met expected standards and were providing good standards of care before they were confirmed in post.
• Staff received an induction and a record of this was maintained. The induction covered a wide range of topics including expectations, care, training, safety and key policies and procedures and these were signed off by a senior member of staff. However, there was very little information recorded to demonstrate how staff understanding or competency was assessed during their induction and what areas of development were identified.
• It was also noted in one staff member's induction it stated they had completed a total of 11 training topics on one day including mental capacity and DoLS, safeguarding, infection control, moving and handling, food hygiene and first aid. This did not provide assurance about the quality of the training provided, as limited time must have been given for each topic in order for all of these to be covered in one day.
• A staff member told us that appraisals were due to start for staff the following week.
• Staff told us they received training and support. Comments included "I did have an induction by the manager when I started. I am working confidently unsupervised now…independently," "We have an appraisal once a year by the manager," "We are well trained, working in a team and delivering good care to our residents," I feel I am well trained here and don't have any concerns."
• We requested records of staff meetings for the previous six months. We were provided with one set of minutes. No other records were provided to demonstrate further meetings had taken place.

We recommend the service seeks advice from a reputable source to improve the approach to developing staff and promoting good practice.

Supporting people to eat and drink enough to maintain a balanced diet
• People were not always offered choices at mealtimes. The chef confirmed the main meal was prepared and then if staff told them people did not want what was on offer they would prepare something else. They said if they saw people before preparing lunch they would ask them if they were happy with the meal being served that day and prepare an alternative for them if not. However, people were not routinely asked what they would like to eat and supported to make choices.
• Mealtimes we observed were very quiet and staff did not engage with people other than to put their meal in front of them.
• We asked the chef how they knew what people's dietary needs were. They said staff would tell them if there was anything they needed to know when they came on shift. When asked, they said no-one living at the service had any specific dietary needs but they cut food up into small pieces for three people who they said needed this.
• When asked if anyone had any needs relating to diabetes the chef said there were people in the service who had diabetes but this was 'controlled' and therefore they did not have any specific needs relating to this. They said they would not give them very sweet puddings such as meringue or treacle pudding. This did not give assurances people's dietary needs were being safely managed.

We recommend the service follows good practice to improve people's mealtime experiences, offering choices and ensuring dietary needs are met.

• People's comments about their diet included "I definitely get enough to drink. I always have orange juice at breakfast and apple juice at tea time…I like to think I get what I need." Another person said "We seem to be on a regular diet of stews and casseroles. There is never a choice for us. A favourite dish of mine is macaroni

cheese. The chef did it for me once and it was lovely."
• A relative told us "The food appears very good and caters for the individual. Sometimes my (family member) is unwell and requires a lighter meal and this is supplied for her in her room. Drinks are regularly supplied and checked so that my mother always has water or refreshment."

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

At our last inspection we recommended the service sought advice from a reputable source about improving the environment for people with dementia. At this inspection we found improvements had not been made.

• The premises looked worn in places. Some carpets and flooring needed replacing and bedroom furniture provided by the home was basic and not always in good condition.
• There was a small lounge next to the kitchen which was not being used effectively and we did not see any one go in there. It was being used to store broken and unwanted furniture and boxes. This room had been cleared of the unwanted items and boxes by the second day of our inspection.
• We noted the addition of memory boxes outside four bedrooms. Memory boxes are boxes that contain an item or items which are meaningful in some way to a person with dementia. This may be a treasured personal item, or an object that someone with dementia can associate with their past. None of the boxes had been put to use and just contained a picture insert supplied with the box.
• Lifting equipment was provided, to assist people with daily living tasks. There was a passenger lift and a stair lift to help people move between the ground and first floors. There was level access around the building.
• A quieter area had been created close to the main lounge, which we saw someone using.

Supporting people to live healthier lives, access healthcare services and support
• People were supported to access healthcare services.
• One person told us "A GP comes here so I'm confident that if I'm ill it will be dealt with properly." A relative commented "I have found that the staff and the management supported (family member) and have acted very quickly to contact her doctor, who on several occasions arranged for the district nurse to visit my (family member)."
• We saw staff referred people to healthcare professionals when needed. For example, if a urine infection was suspected. There was regular input from a physiotherapist to help improve people's mobility and stamina.

Staff working with other agencies to provide consistent, effective, timely care
• Staff co-operated with external agencies involved in people's care, such as the local authority.
• Staff attended handover meetings between shifts, to share information about people's well-being and to communicate any tasks that required follow up. A written record was kept of these meetings, for reference.

Requires Improvement

Is the service caring?

Our findings

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

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

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence
• We observed little engagement between staff, the provider and people living at the home. There were several occasions where staff and the provider went into people's rooms without acknowledging them or asking how they were.
• Interactions by staff were task-based rather than focused on the needs of people. For example, a member of staff was observed standing over someone whilst supporting them with their lunch, rather than sitting next to them.
• Another member of staff left a hot pudding in someone's room without telling them they had left it or what it was or asking if they wanted it. The person was still eating their main meal and it was very likely the pudding would have been cold by the time they were ready to eat it.
• Three people's food was cut up before it was served to them. The need to do this was not recorded in their care plans. This made assumptions about people's abilities to manage independently.
• People did not always look well-groomed and supported with their dignity. Examples included a person wearing stained shoes. Gentleman had not been supported to shave. Some people's clothes were not clean and people's hair did not always look as if it had been washed or cut recently.

This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the provider had failed to ensure people were treated with dignity and respect.

• We received some positive feedback about how staff treated people. One person said "Some carers I really like…because I can have fun with them." A relative told us "During the day, staff take time to chat with her and listen to her stories about the life she has lived. One member of staff will even sings hymns with her while preparing her for bed. In my experience many of the staff show kindness to my (family member) that helps her feel at home."

Supporting people to express their views and be involved in making decisions about their care
• We did not observe people being involved in making everyday decisions. For example, where they wanted to sit at mealtimes.
• The provider had used surveys to seek feedback from people living at the home. These had been completed with assistance from staff. We saw actions arising from the survey had been added to the home's improvement plan.
• We were told residents and relatives meetings were planned for the year. No evidence was provided of any

meetings having taken place.
• The provider said a weekly manager's surgery was held which people using the service, staff and families could use.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed 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

At our last inspection we recommended the service followed good practice in producing care plans which outlined the support people need to manage their diabetes. At this inspection we found the provider had not made significant improvements.

• We looked at the care plans for two people diagnosed with diabetes. Information was generalised, without any information specific to the person. For example, one care plan said the person "follows a diabetic diet and his diabetes is diet controlled." There was no guidance on want was meant by this. The care plan said the person's "sugars are to be checked once a week and recorded." The normal blood sugar range for the person was not noted anywhere. One section said "most people need medicine to control their type 2 diabetes". However, there was no indication if the person was prescribed any medicine. There was the potential that staff may not be providing appropriate support to people with diabetes and they could be unaware when they needed to seek medical advice, without the proper guidance in place.

Care plans did not identify people's full range of needs and were not always person-centred.
• Two care plans had several sections where there was no information recorded. For example, one person's care plan did not provide details of medical history, sexuality, elimination and mobility. There were significant needs around supporting the person with elimination. Their room was malodorous on both days of the inspection and they needed assistance to manage laundry. There was no guidance in place to support the person with this.
• Another person's care plan did not record how they walked or whether staff needed to assist them to move. There was reference to a Zimmer frame but there was nothing recorded in the section under mobility. This meant there could be inconsistencies in how the person was supported.
• We read under 'critical information' in one care plan the person needed a diet 'as per speech and language therapist guidance'. However this guidance was not provided under any sections of the care plan. This meant staff may not be providing the correct texture or type of diet the person required.
• Two people's records showed they were obese and gaining weight. There was no mention of this in one of the care plans. In the other care plan it said food intake needed to be monitored. Staff were keeping records of meals but this did not include how much was actually consumed. For example, toast was eaten at breakfast but there was no indication how many slices and what was on it, a full cooked breakfast was eaten on one day but there was nothing to describe what it consisted of. Staff would therefore not be able to quantify the amount of food consumed to support the person appropriately.
• There was a lack of personalised information to support people with medical conditions. One person

needed support with mental health needs. Their care plan contained a lot of generalised information about the condition but not how if affected the person and whether they experienced any or all of the long list of symptoms which were recorded. This meant staff may not be able to support them appropriately if they did not understand their specific needs.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had failed to ensure people received care and treatment which met their needs and reflected their preferences.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

At the last inspection we recommended further work was undertaken to ensure the home fully complied with the Accessible Information Standard. At this inspection there were no examples to demonstrate improvement.

• People's communication needs had been assessed and recorded in their care plans, alongside any aids they needed, such as glasses and hearing aids.
•The provider told us there was a picture menu board. This was outside the office and not easy for people to notice. We were told there were large print menus but we did not see any of these in the dining room at meal times.
• The provider said they were able to provide documents in large print and could arrange translators, if required. There were no examples where this had been put to use.

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
• There was little stimulation provided for people at the home. People spent most of their time in the lounge watching television or asleep, or in their rooms.
• An activity co-ordinator had been appointed but was not working on either day of the inspection.
• A member of staff told us an entertainer had resumed weekly visits to the home.
• One person said in the residents' survey they would like to be able to go out to the shop. This had not been facilitated due to the pandemic.
• People told us birthdays were celebrated and they were asked what special food they may like to have.
• Relatives told us they had been helped to communicate with family members during the pandemic, including using technology. They said they could now visit. One relative said "I have been informed by email of the visiting procedures required and my mother has been enjoying more visitors recently; there are regular timeslots available to book. During lockdowns my mother's family and friends have been able to contact her by telephone. This has helped her to keep connected to the family."

Improving care quality in response to complaints or concerns

At the last inspection we recommended the complaints procedure was updated to include details of the Local Government and Social Care Ombudsman (LGSCO). At this inspection we found improvements had been made.

• A revised complaints procedure was in place. This included all required information, including the right to contact the LGSCO if the person was not satisfied with how the provider had dealt with any complaint.
• A relative told us "If I have any concerns I can discuss these with the manager, she listens and if action is required this is done promptly. If I wish to speak with the manager in person I can make an appointment to see her to discuss concerns or changes."
• We were unable to assess whether any complaints had been received and how these were handled. Records of complaints could not be located by the provider during the inspection.

End of life care and support
• No one was receiving end of life care at the time of the inspection.
• We asked the provider what training and support was given for end of life care. We were told they did not consider end of life training to be mandatory but had provided this in the past and previously accessed external support.

We recommend the home develops staff to become end of life champions to make links with hospices and research training so that this learning can be put into practice as people's health deteriorates.

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 promoting an open, fair culture.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed 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 the provider had failed to ensure systems and processes had been established and operated effectively to assess, monitor and improve the quality and safety of the service provided. The registered person had not sought and acted on feedback from relevant persons and other persons, for the purposes of continually evaluating and improving the service. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvement had not been made at this inspection and the provider was still in breach of regulation 17.

• The home had a manager in post. They had applied to become registered with the Care Quality Commission.
• There was a lack of contingency planning to run the home safely and effectively when the manager was away.
• When the manager was on duty, we were able to access records and they were able to provide information held on the computer to demonstrate the things we enquired about. In the manager's absence from work, we found the home to be disorganised and the provider was unable to locate files containing basic records such as accident reports and complaints. They were unable to answer questions about the daily operation of the home, such as queries about the staff rotas.
• After the inspection, we asked the provider to send records we requested and answer queries, within four working days. Some information was sent within this time, other information came a further three days later. We were concerned important but everyday information about people's care could not be found by the provider at the time of the inspection and then the further delay afterwards. Even then, we were not provided with everything we requested. This demonstrated the home did not have an adequate management structure in place and poor provider oversight of the service.
• We asked to look at records of monitoring and auditing, covering the previous 12 months. We could see three audits had taken place of medicines practice and three of infection control practice. We were only provided with a further two audits covering the 12 month period. Whilst these did identify some areas for improvement they did not identify the range of issues we found. This showed quality assurance systems were ineffective in identifying risks to people's health, safety and welfare.

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

Regulations 2014, as the provider had failed to ensure systems or processes were in place to assess, monitor and improve the quality and safety of the service.

• Relatives spoke positively about the manager. One said "I have a very high regard for (the manager) who seems to have a remarkably good way of managing the home since she has been put in charge. She has been unbelievably helpful during lockdown to keep us informed and to help us communicate with my (relative)." Another told us "The manager is always helpful and keeps me up to date of changes with my (relative's) health condition. Another relative told us "I speak with the manager of the home regularly and she is very helpful."

At our last inspection the provider had failed to notify the Commission of all incidents it was required to. This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009

Enough improvement had not been made at this inspection and the provider was still in breach of regulation 18.

• We received notification about some events the home was required to tell us about, such as injuries and safeguarding concerns.
• However, we had not received notifications of any DoLS authorisations, as required. We had only received notification of five DoLS applications since 2016 under the provider's current and previous registration.

This was a continued breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009 as the provider had not notified us of all events it was required to.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• The findings from our inspection showed the home was not always working in a way which was person-centred and empowered people, for example to make choices and have a good quality of life.
• Apart from a residents' survey, there was little to demonstrate people were consulted about their care and could engage in how things were done at the service.
• There was not always a good working culture at the home. Although staff said they felt supported, there was little evidence of staff meetings, recorded supervision and good quality training. One member of staff commented "The morale here is not good, it is terrible, we desperately need more hands".
• The inspection showed the provider was out of touch with how things operated at the home and what was required to ensure people received a safe service.

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

At the last inspection we recommended the registered manager followed good practice towards fully demonstrating the duty of candour requirement. At this inspection improvements had not been made.

• We asked the provider how they were meeting the duty of candour requirement. The information they provided showed there was still a lack of understanding about what is required. They had confused duty of candour with informing us about notifiable incidents and making safeguarding referrals, which are separate requirements. There are specific things providers need to demonstrate duty of candour: telling the person (or, where appropriate, their advocate, carer or family) when something has gone wrong, apologise to the person (or, where appropriate, their advocate, carer or family) and offer an appropriate remedy or support

to put matters right, if possible. There was no evidence to show the provider had done this.

We recommend the provider improves their understanding of the duty of candour requirement and is able to demonstrate the principles.

Continuous learning and improving care; Working in partnership with others
• The quality of people's care had deteriorated from the previous inspection. Advice to improve practice was not being incorporated into people's care, to ensure they were supported in the best possible way.
• We were not provided with evidence of any learning from incidents, to prevent people coming to harm.
• We could see staff worked alongside health and social care professionals but advice was not always followed. For example, from the speech and language therapist and a mental health professional.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered person had not notified the Commission without delay of the incidents specified in the regulation. The provider had not notified the Commission of any request to a supervisory body for a standard DoLS authorisation, if it was preceded by an urgent authorisation and the date and outcome of the request or application or reason for its withdrawal. Regulation 18(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person had not ensured people's care was appropriate, met their needs and reflected their preferences. Regulation 9(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not treated with dignity and respect in the provision of their care. The registered person did not support people's autonomy and independence.

Regulation 10(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from abuse and improper treatment. The registered person had not ensured people were not deprived of their liberty without lawful authority. Regulation 13(1) & 13(5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The registered person had not ensured all premises and equipment were secure, suitable for the purposes for which they were being used and properly maintained. Regulation 15(1)

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 People's care and treatment was not provided in a safe way. The risks to people's health and safety had not been adequately assessed and the registered person had not done all that is reasonably practicable to mitigate any such risks. The registered person had not adequately assessed the risk of and prevented, detected and controlled the spread of infections. Regulation 12(1)

The enforcement action we took:

served warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes had not been established and operated effectively to assess, monitor and improve the quality and safety of the service provided. The registered person had not sought and acted on feedback from relevant persons and other persons, for the purposes of continually evaluating and improving the service. Regulation 17(1)

The enforcement action we took:

served warning notice