Dorking Residential Care Homes Ltd

Nower House

Inspection report

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Date of inspection visit:
17 December 2021

Date of publication:
09 February 2022

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
Nower House is a residential care home providing personal care to up to 50 people aged 65 and over, some of whom live with dementia. At the time of the inspection they were supporting 35 people. The care home is one adapted building and at the time of the inspection people were only residing on one floor, the ground floor. The lower ground floor was only being used for the kitchen and domestic purposes.

People's experience of using this service and what we found
People were not always kept safe from risks. Risk assessments were not always completed and care plans did not always adequately detail risks.

The home did not have enough staff to meet people's needs. We saw staff did not have time to support in a personalised way and people and staff told us there were not enough staff working at the home. This had impacted the ability of staff to meet basic bathing choices of people, such as more than one shower a week.

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; the policies and systems in the service did not support this practice.

The environment of the home did not always meet the needs of the people living there. For example, it was not a dementia friendly environment.

There was not always full oversight of the quality and safety of the home. There were some essential audits not being completed, these included quality assurance audits. This meant that shortfalls in practices were not being identified and action could not be taken to drive improvement in the home.

For the last two inspections the provider had failed to make adequate improvements to ensure people were kept safe and the home was effectively monitored. As a result, in certain areas the home had deteriorated.

People told us they felt safe and staff were caring towards them. However, the level of care people received had been directly impacted by the shortage of staff. Staff were knowledgeable in safeguarding procedures they needed to follow.

People told us they felt comfortable to raise complaints and they felt they could talk to the registered manager.

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)

The last rating for this service was requires improvement (published 03 August 2021) and there were multiple breaches of regulation. The provider had a condition placed on their registration to complete monthly audits specific to the concerns found at the last inspection. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about training and staffing. A decision was made for us to inspect and examine those risks.

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

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

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.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Nower House

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
This inspection was carried out by three inspectors.

Service and service type
Nower House 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.

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

During the inspection
We spoke with 10 people who used the service and one relative about their experience of the care provided.

We also spent time observing staff interactions with people. We spoke with nine members of staff including the registered manager, clinical lead, senior care workers, care workers and the chef. We also spoke with the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

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

After the inspection
We continued to seek clarification from the provider to validate evidence found. We also sought an urgent update following the inspection to ensure the provider had made immediate changes to keep people safe. We looked at training data and quality assurance records. We spoke with one professional who regularly visit the service. We also spoke with four relatives on the telephone to gain their feedback about their experience of the care provided.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Using medicines safely; Preventing and controlling infection; Learning lessons when things go wrong

At our last inspection in May 2021 systems were either not in place or robust enough to demonstrate risk was effectively managed and that the failure to manage medicines safely placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection not enough improvement in how risks to people's safety were recorded and medicines were managed. This meant the provider was still in breach of regulation 12.

● People's risks were not always identified, recorded and assessed correctly. Where we had been informed people had individual risks these were not always present in care plans to provide staff with guidance and advice on how to manage these risks.
● One person was at risk of exhibiting behaviour that challenged. There was no mention of this in the person's care plan. This meant that not all staff were aware of this risk, how to manage this behaviour or had knowledge of potential triggers. Due to staff shortages agency staff were being used and this information was not available for them to ensure safe support for this person.
● One person was at risk of falls, this again was not mentioned in the care plan and there was no clear risk assessment in place for this. This meant that some staff did not know the risk of falls for this person or how to prevent future reoccurrences. This person had also experienced a recent fall.
● The registered manager told us that eight people were supported with a softened diet, however only one of these people had been referred to the Speech And Language Therapist (SALT) team. This meant seven people were receiving a softened diet when they had not been properly assessed as requiring one and there was no care plan or risk assessment in place to detail why they had a softened diet or how to support them safely. This placed people at risk of choking.
● Environmental health and safety checks were not routinely completed. There were outstanding action plans for legionella and asbestos risk assessments. For example, an action to regularly flush unused taps had not been completed or recorded. The home had recently been subject to a re-arrangement meaning there were many unused areas in the lower ground floor that were not being maintained regularly to avoid the risk of legionella.
● There were outstanding actions from a fire risk assessment that had been completed in February 2021. This included ensuring every person had a Personal Emergency Evacuation Plan (PEEP) in the fire folder. This meant that if an emergency occurred, emergency services would be unable to establish what people's evacuation and mobility needs were to remove them from the building safely.
● Although some improvement was noted in the management of medicines, there were still some

inconsistencies. This included some handwritten entries on medicine administration records (MAR) sheets not always being signed or counter-signed, this is good practise to avoid instructions being copied incorrectly and medicine errors occurring as a result. Since the last inspection medicine errors had occurred. In addition to this stock counts were not always being brought forward. This meant that if medicine errors occurred, they would not always be identified in a timely way.

● Not all topical creams were being recorded correctly. Some people who were supported with topical creams did not always have MARs in place, this meant there was no guidance on the prescriber's instruction and record of when it had been administered. Where people did have them in place there was no guidance for staff on how or where to place the creams. This meant people were at risk of not receiving their medicines in accordance with the prescriber's instructions.

● There were no systems in place to monitor and assess the ongoing competency of staff. This meant that the skills and experience of staff administering medicine could not be assessed.

● Accidents and incidents were being recorded, however, these were not managed and acted upon in a timely way. There had been no recent reviews completed of accidents and incidents that had taken place in the home. This meant that no trends or patterns could be identified to potentially prevent reoccurrence.

● We were not assured that the provider was using PPE effectively and safely. We saw several instances where staff were not wearing PPE in line with guidance. A member of staff was seen on more than one occasion not wearing a face mask at all in areas of the home where staff were required to wear masks. There were also several occasions we saw staff members wearing their masks under their chins.

● Other members of staff were seen to wear new aprons to support people with eating at lunchtime. However, they then walked through the home to support other people into the dining area. This meant that the aprons were ineffective in reducing the risk of infection.

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. We saw that there were domestic staff cleaning throughout the day, there was no record of what cleaning was being completed. The lack of cleaning schedules meant that the registered manager had no oversight of what cleaning responsibilities were being completed and what areas of cleaning needed improvement.

The failure to ensure risks to people's safety and the home were robustly monitored and that safe medicines systems were followed was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Immediately after the inspection assurances were requested from the provider . The management team provided us with assurances that the people receiving a softened diet had all been subsequently referred to the SALT team and their care plans had been updated to also include thorough risk assessments.

● People's dietary needs had been recorded on a document that was now displayed in the kitchen and this was also added as an agenda item to be discussed at all handovers.

● Some improvements in medicines management had been made since the last inspection . The home now had one centralised medicine/clinical room. This ensured that medicines were easier to be managed. A new role had been created for a clinical lead to take responsibility and drive improvement. This was seen to have already begun with various new systems, an example was seen where they had completed medicines audits and identified some areas needing improvements and action taken.

● We were 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 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. Temperature checks were being taken of all visitors at the entrance of the property, this was also accompanied by lateral flow testing (LFT) and a signing in procedure to ensure people entered the home safely. The registered manager also had records to show all staff had taken part in the national vaccination programme.

We have also signposted the provider to resources to develop their approach.

Staffing and recruitment
● There were not always enough staff to meet the needs of the people living in the home. People said, "Staff are very rushed, we don't like to bother them, they are trying their hardest but they are very short." Another person said, "I don't really bother using my call bell as I know staff are too busy to answer".
● It was apparent that staff shortages were having a direct impact on the level of care people were receiving. One person said, "They're just so busy, I often don't want to bother them or make a fuss, so I don't always get the support I need."
● Staff told us that they were feeling the strain of not having enough staff. One staff said, "We need more staff, it makes me sad because the people here deserve a better level of care." Another member of staff said, "They tried to move the building around to make it better for the low level of staff, but it just seems to be worse for the people. We used to have time for people, I think it is now having a direct impact on care."
● We saw from staffing rotas that the working rotas showed there were rarely the assessed number of staff on a shift the majority of the time. This requirement had been calculated by the registered manager's dependency tool.
● Following a number of staff leaving the employment of the home, the registered manager and the management team had reviewed the deployment of staff and had moved all residents to one floor. Although this meant that people were closer for staff to support quickly there was still a shortage of staff and a number of people who spent all of their time in their rooms. This meant people were at risk of isolation or not being able to notify staff if they needed help.

The failure to ensure there were enough staff to meet people's needs was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● After the inspection we were assured they were reviewing their staff deployment and had asked all people how frequently they would like a shower to ensure they met these needs.
● The registered manager was intending to be involved with a government scheme to address the current national staffing issue in care homes. This includes offering accommodation for trained care staff from other countries to improve the current staffing issue.
● The registered manager and the management team had made the decision to not admit new people in to the home until they had resolved training issues and staffing level issues.
● The registered manager followed safe recruitment processes. This included professional references and checks with the Disclosure and Barring Service (DBS). This ensured people were suitable to work with and support the people living in the home.

Systems and processes to safeguard people from the risk of abuse
● People and relatives told us they felt safe with staff supporting them. One person said, "I know they're rushed, but I've never felt unsafe." Another person said, "I know they need to improve but I've always felt safe."
● Staff received safeguarding training and showed good knowledge in how to report a safeguarding

incident. One staff member said, "I would follow the reporting system and if I wasn't happy, I would raise it with yourselves (CQC) and the local authority."

● The provider had a safeguarding policy in place with guidance and advice for staff to refer to if they had any concerns.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

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

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

At our last inspection in May 2021 we found the provider had failed to complete decision specific capacity assessments. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found continued concerns regarding how the principles of the MCA were applied. This meant the provider was still in breach of regulation 11.

- The registered manager had not completed any further decision specific DoLS applications since the last inspection and the concerns found in May 2021 were still outstanding. This meant people's rights were being restricted without the required authorisation, for example, people had restrictive measures in place in their rooms such as sensor mats and bed rails.
- We were told at the last inspection that a DoLS tracker was to be introduced. This had still not been introduced meaning that there was no effective management of applications and no oversight of whether the correct procedure was being followed.
- Although capacity assessments had been completed, these had not led to best interest discussions being held. This meant people were being restricted without the legal framework being in place.

The failure to ensure people's rights were upheld in line with the MCA was a continued breach of regulation

11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● As part of conditions placed on the providers registrations at the previous inspection the provider submitted monthly audits to CQC. It was clear from these, work had been done to complete initial capacity assessments, however, this had not then led to best interest discussions.
● People told us that staff always gave them choice and asked for their consent. One person said, "They (staff) are always asking if I'm happy for them to help me with things like washing."
● Staff showed knowledge in following the principles of the MCA. One staff member said, "You should never assume someone lacks capacity."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs and risks were not always detailed in their care plans. For example, nutrition and hydration plans did not always detail full assessments for people on softened diets. Nutrition and hydration care plans did not always detail people's choices and preferences for staff to be aware of.
● Some needs had been assessed and were detailed in the new care plans. These included people that were at risk of pressure areas and skin integrity. This had been improved since the last inspection.
● Since the last inspection the registered manager had stopped using a Monitored Dosage System (MDS) which had previously been used for the storage and administration of the majority of people's medicines. These systems are commonly referred to as blister packs. The Royal Pharmaceutical Society (RPS) and NICE recommend that the MDS system should only be used in order to meet the specific needs of an individual. Previously this had been used to prevent errors in the absence of training for staff. The management were now in line with all guidance and had a fully trained clinical lead to oversee this.

Staff support: induction, training, skills and experience
● Staff confirmed that they had received all the training they needed to complete their role. One staff member said, "I am happy with my training and if I thought I needed more, I would raise it."
● Staff received an induction where they would complete training and "shadow" experienced members of staff. We received mixed feedback from staff about their induction periods. Some staff told us that they enjoyed their induction period and benefitted from this time, however, others said that their induction had not been completed in a timely way.
● Staff completed regular online training. However, there were some specialist training that had not been offered to staff. For example, not all staff had received International Dysphagia Diet Standarisation Initiative (IDDSI) training, however, they were supporting people with softened diets. Staff appeared to still have knowledge in this area from previous experience, however, had not received up to date training.

Supporting people to eat and drink enough to maintain a balanced diet
● We received mixed feedback regarding food. One person said, "The food is very nice." However, another person said, "There's no choice, I rarely get food I enjoy." A relative also said, "[Person] loves (lists of preferred foods) but there doesn't seem to be that choice."
● There were no systems in place to enable people to feedback about the food, and no evidence of any feedback being acted upon. The registered manager confirmed they had a plan to meet with the chef and people to build a new, refreshed menu.
● People were not seen to be given choices at lunch time to confirm their preference. One member of staff was seen to verbally ask a person living with dementia, that was not able to communicate verbally, what they wanted for lunch. After no obvious interaction or response the staff member chose the lunch the person would have. No other methods were used to support the person to make a choice for example by being shown plates of food to choose from.

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

● The home had been changed to adapt to the staff shortages. To support staff deployment all people had been moved to one floor. This meant that people living with dementia were not in surroundings that they had been accustomed to. There had been no consideration or consultation with people to consider how the environment could be adapted to help meet the needs of people with dementia in order to promote and maintain their independence.

● Lounge and dining areas were designed to encourage social interaction. For example, dining tables were small to encourage conversations at mealtimes.

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

● The management told us how they worked well with health and social care professionals. One social care professional confirmed, "They [management team] are working alongside me to address concerns found at a recent visit.

● People and relatives told us how staff supported them to access healthcare professionals in a timely way. One relative said, "As soon as [person] needs medical attention they call the GP."

● The home worked with the local GP to address any health concerns. The GP completed weekly visits to assess people in person and the staff also worked alongside the district nursing team.

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.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- People and their relatives told us staff were kind and caring. One person said, "The staff are lovely." A relative also said, "I can't fault the staff, they are brilliant, they just need more of them."
- Staff told us that they don't have the time to give good quality care. One staff member said, "We get the basics done, the people are safe, but there is nothing meaningful for people. It is rare we can stop and have a chat with someone."
- Due to staff shortages people were not always being treated with dignity and respect. For example, at the time of the inspection people were only being supported with one shower a week. This upset people and meant that they were not being supported the way they wanted to.
- Staff were not always encouraging people to be independent. One person said, "I'd love to be able to make a cup of tea for myself. Especially seeing how busy staff are, I'd love to just get a drink when I want."
- Staff received equality and diversity training and were knowledgeable in this area. One staff member said, "You can never assume one person is the same as the next, they all need to be treated differently in a way which they want."

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

- The feedback from people about involvement in making decisions was mixed. One person said, "I'm as involved as I want to be." Another said, "I can't say I've ever been involved in a review or made a decision."
- Some care plans detailed people's involvement in reviews of their care plans. Since the new care plans had been introduced there was a lot more details that people had been involved with adding.
- People told us they felt comfortable approaching staff with their views. One person said, "I know staff listen to me if I ever want to tell them something."

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

At our last inspection in May 2021 we found the provider had failed to design care with a view to achieving service users' preferences and to include end of life care planning .This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found continued concerns regarding how people's care was planned. This meant the provider was still in breach of regulation 9.

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.

- People were not always given choice. People living with dementia that were non-verbal were not given choices by staff. We observed staff telling people they were going to take them to an activity or another part of the home rather than asking them if they wanted to go.
- Improvements had started to begin work on establishing people's life histories, some care plans still lacked these personalised details. People living with dementia had little detail about their preferences and likes. This meant staff did not always have information about people to support orientation and discussion.
- Some staff were knowledgeable about people's personalised needs, however, some staff lacked this pertinent knowledge. With the absence of these details in care plans this meant that there was a potential gap in knowledge for staff to be able to deliver quality person-centred care.
- Since our last inspection all people now had a new care plan in a digital form. these were still missing guidance for staff relating to personalised risks, needs and preferences. These included details of people's behaviours and how staff could support them and avoid triggers. Some people had behaviour that challenged or low moods, there was no detail for staff in care plans on how to manage these in different ways to meet the person's needs. This meant staff may not be provide consistent, effective care.

The failure to ensure person-centred care was a continued breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Since the last inspection oral care plans and end of life care plans had been introduced. People and their family had been asked specific details of what their preferences would be if they entered this stage of their life.

Improving care quality in response to complaints or concerns

● People told us that they felt listened to. One person said, "I know the registered manager would listen to me and act on any concerns."
● There was no clear oversight of the complaints procedure at the home. There was no audit to confirm action had been taken in a timely way. One staff member said, "I think they [registered manager] is very good at listening, but they don't always act, I think they just have a lot to do and can't keep track."
● There was no process to ensure they learnt from complaints that had been raised and taken action in a timely way. There was no evidence of learning from complaints and concerns that had been raised in order to aid improvement.

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 had been a new activities team introduced at the home. This team were driving improvement to staff's knowledge of people's individual interests. This work had only recently started so there were no clear examples of how this had affected activities.
● People and relatives told us how they had been supported to maintain contact throughout the pandemic. One relative said, "[Person] has a patio area outside their room so we could meet and wave through the window during the isolation period."
● The registered manager ensured people received as many regular visits from their relatives as possible during the pandemic. There were visitor protocols in place to ensure people could have visitors as often as possible. This was all whilst still maintaining compliance with government guidance.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection in May 2021 we found the provider had failed to ensure consistent management oversight of the service, respond to shortfalls in a timely manner and have an accurate, up to date record for each person. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found continued concerns regarding management oversight of the home. This meant the provider was still in breach of regulation 17.

After the last inspection in May 2021 we added positive conditions to the home's registration. This was to complete a variety of audits to ensure oversight of the home. These had been completed, however, had not been built upon to promote overall improvement to the quality of care being provided.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

- The registered manager did not always have complete oversight of the home. There were no overarching quality assurance audits being completed to identify any shortfalls, ensure action was taken in a timely way to drive improvement at the home.
- There was an ongoing action plan being completed by the registered manager and the nominated individual. There was a copy on the wall of the office for staff to review as well. This was an open, transparent way of showing the ongoing plan to all staff, it was not up to date to detail all action that was still required to be completed.
- Some audits had been introduced since the last inspection, however, these had not always been effective. For example, the medicine audit had not shown the shortfalls in practices and the capacity assessment audit had not driven the improvement to include best interest decisions and DoLS applications.
- Care plans did not always detail person-centred care and people were not always being supported by staff in a person-centred way.
- There was no oversight of the home regarding learning to improve care. There was no analysis of accidents and incidents or concerns and complaints. This meant that the registered manager and the management team could not drive improvement effectively.
- Not enough improvement had been made since the last inspection. There were similar concerns found from the last inspection. For example, there were risk assessments that had not been completed.

● The staffing levels were having a direct impact on the level of care and meant that people were not receiving person-centred care. This included people living with dementia not always getting choice and all people living in the home being restricted on routines such as one shower a week.
● Due to the challenges that the registered manager had faced since beginning his post, for example the staffing challenges, they had found it difficult to make improvements to promoting a positive culture that was inclusive for people. The registered manager confirmed that they had focused their priorities on managing the staffing levels and completing the audits to be in line with their positive conditions on their registration. They said, "I have a plan to include more people in decisions about changes that are going to be made to the home, but at this moment in time we have to focus on the staff shortages as a priority."

The failure to ensure consistent management oversight of the service, respond to shortfalls in a timely manner and have an accurate, up to date record for each person was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager and the nominated individual were open and honest during the inspection as to what improvement was still required at the home.
● The registered manager had submitted relevant notifications to CQC, the local authority and other professionals when incidents had occurred that were notifiable. We saw evidence of information sharing to ensure all professionals were aware of any incidents.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● There were staff meetings which gave staff opportunities to voice their opinions and any concerns. Staff also told us they had appraisals as well. These were not always effective in action being taken. One member of staff said, "We've kept saying we need more staff, but nothing is happening."
● There were feedback records and records of resident and relative meetings. However, these were not always regular. This meant it was not possible to build a full picture of people's views.
● The staff and the registered manager worked well with some health and social care professionals. Evidence was seen of regular referrals for some people and aside from SALT referrals, action taken in a timely way in response to health concerns.

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 9 HSCA RA Regulations 2014 Person-centred care The failure to ensure person-centred care was a continued breach of regulation 9

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The failure to ensure people's rights were upheld in line with the MCA was a continued breach of regulation 11.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The failure to ensure there were enough staff to meet people's needs was a breach of regulation 18.

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 The failure to ensure risks to people's safety and the home were robustly monitored and that safe medicines systems were followed was a continued breach of regulation 12.

The enforcement action we took:

Warning notices

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The failure to ensure consistent management oversight of the service, respond to shortfalls in a timely manner and have an accurate, up to date record for each person was a continued breach of regulation 17.

The enforcement action we took:

Warning notice.