Alliance Care (Dales Homes) Limited

The Berkshire 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
The Berkshire Care Home is a care home with nursing that provides a service for up to 58 older people, some of whom may be living with dementia. At the time of our inspection there were 40 people living at the service. The Care Quality Commission (CQC) regulates both the premises and the care provided.

The care home is located in a residential area. Accommodation is arranged over two floors. There are a number of communal lounges and a communal dining area. There is a large garden surrounding the building.

People's experience of using this service and what we found
Leadership, management and governance systems were poor and did not demonstrate the service was well led, people were safe, or their care and support needs were being consistently met. Systems in place to oversee the service and ensure compliance with the fundamental standards were not always effective. They did not enable the registered manager and provider to identify when their legal responsibilities were not being met. The health, safety and welfare of people using the service, and others, were not always managed effectively and required records were not always kept or available.

Risks to people were not effectively assessed and mitigated. Staff were not deployed effectively to provide person-centred care. Medicines were not managed safely. People were placed at risk of harm due to a lack of information for staff about how to manage people's medicines. Incidents and accidents were not analysed to prevent recurrences and keep people safe. Recruitment practices were not sufficient or robust enough to ensure suitable staff were employed.

Assessments of people's care and support needs were not sufficiently detailed to enable staff to provide safe, effective care. Care plans did not contain adequate information for staff to help them manage people's health conditions. Staff did not always work effectively with professionals from outside agencies to promote people's health and wellbeing.

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.

People's dignity and independence were not valued and promoted. People were left unattended for long periods of time and had to wait extended periods to receive support from staff. People were not supported to maintain their independence.

People were not involved in planning their care and support. There was a lack of evidence to show people, their family members, professionals and people's legally appointed representatives had been involved in making decisions about their care and support.

The provider had failed to notify the local authority safeguarding teams promptly when notifiable safety incidents occurred. The provider had not maintained a complete and accurate record of complaints and investigations into complaints.

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

Rating at last inspection
The last rating for this service was good (published 07 April 2019).

Why we inspected
The inspection was prompted in part by notification of a specific incident. Following which a person using the service died. This incident is subject to a formal investigation. As a result, this inspection did not examine the circumstances of the incident.

The information CQC received about the incident indicated concerns about nursing care, the management of specific health conditions and unsafe medicines management. This inspection examined 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 the safe, effective, caring, responsive and well-led sections of this full report.

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

The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We 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 identified breaches in relation to safe care and treatment and good governance. We have served warning notices on the provider.

We have also identified breaches in relation to person centred care, dignity and respect, need for consent, premises and equipment, receiving and acting on complaints, staffing and fit and proper persons. We issued requirement notices and asked the provider to send us a report that says what actions they are going to

take.

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

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 meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 6 months to check for significant improvements.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was always not caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

The Berkshire Care Home

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was completed by two inspectors, a pharmacist inspector, a specialist advisor and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we held and had received about the service since the last inspection. We sought feedback from the local authority and other professionals who work with the service. We checked information held by the Food Standards Agency. We contacted the local authority safeguarding team. We

looked at online reviews. 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 looked at the notifications we had received for this service. Notifications are information about important events the service is required to send us by law. We used all of this information to plan our inspection.

During the inspection
We spoke with the registered manager, a regional support manager, the managing director for the south region, four nurses, one healthcare assistant, the activities coordinator, an administrator and three visiting health professionals. We also spoke with one relative and 12 people who used the service. We observed people receiving support in communal areas.

We reviewed a range of records relating to people's care. These included, four people's care and support plans, six people's care plans for specific conditions, four people's daily care logs, safeguarding referrals to the local authority. and 13 medicines administration records, We also reviewed records relating to staff including, four full and two partial recruitment files, staff training records, five staff supervision records, staff rotas and the provider's staffing allocation tool. Management records were also reviewed including records related to premises safety management, incidents and accidents logs, call bell response times logs, the complaints log and complaints procedure.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with one staff member. We also sought written feedback from three professionals who regularly visit the service. We received feedback from two visiting professionals.

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 good. 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

- Staff did not always effectively monitor and manage risks to keep people safe from harm.
- In another example a person sustained a burn from a cup of tea. Staff did not treat the burn appropriately and the person developed an infection for which they were admitted to hospital.
- In a further example a person who was identified as being at risk of falls sustained an avoidable injury. Staff ensured the person slept in a low bed with a 'crash mat' placed on the floor to prevent injury if the person were to fall out of bed. As the person had been hitting their hand on the wall next to their bed, staff had removed the crash mat from the floor and placed it between the person's bed and the wall. The person then fell out of bed onto the floor and sustained a head injury.
- A radiator in a person's bedroom did not have a cover. Staff placed a thin, mattress between the radiator and the person's bed. This posed the risk of the mattress falling onto the person. We pointed this out to the management team, who told us a radiator cover had been ordered.
- A person who was at high risk of falls had a thin 'crash' mat beside their bed to prevent injury if they fell. However, the bed was raised up high, increasing their risk of injury. In addition, an overbed table on wheels was placed on the 'crash' mat which again placed the person at risk of injury falling into the table if they were to roll out of bed.

The registered person had not ensured risks to the health and safety of service users were effectively assessed and mitigated. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Risks from the premises were managed and records kept up to date. This included fire safety, electricity, gas, Legionella prevention and control, window restrictor checks and lifting equipment, such as hoists and passenger lifts.
- Actions taken to complete remedial works, for example to the electrical installation and fire doors, were delayed in part due to the pandemic lockdowns. However, evidence was provided to show contractors had completed repairs. Only a small number of outstanding remedial actions remained.

Staffing and recruitment

- Staff were not deployed effectively to meet people's needs in a timely manner.
- The provider's staffing calculator set out the number of staff required for each shift. This was updated at least monthly, or as needed. Although the tool considered people's level of care needs, it did not provide time for environmental factors. For example, time staff needed to move around the building which used more of their available time. The tool listed zero hours for this. The calculator also did not specify staff hours required for other tasks such as training, supervisions and COVID-19 testing.

● Staff also stated they felt at times there were not enough staff members deployed to meet people's needs. They expressed they sometimes felt rushed and under pressure.
● Some people had to wait a long time for personal care. One person had waited until 12:00pm on two days in one week to be assisted to wash and dress, this was not their choice. Another person had also had to wait long periods to be helped to wash and dress. They said, "I get washed usually between 9.30 and 10 o'clock. It depends. Sometimes it can be as late as noon. It is probably when they are short of staff."
● People told us staff were not available to assist them at the times they asked for help. One person said: "I push my bell to ask to be washed and dressed- often they say I will have to wait and that they have to do two or three other people first. I accept that, I have no choice really".
● Call bell log records showed call bells were not answered promptly, within the service's expectation of three minutes. On some occasions call bells were not answered for 10 minutes and on one occasion 30 minutes.
● Some people's care records stated staff should check on them every hour. Two people's care records showed that staff had not been completing these checks consistently. Staff had not completed checks every hour on several occasions.
● Some relatives commented on the staffing levels. One relative stated, "The problem is not enough staff [deployed]. Sometimes [the person] has to wait for long periods of time."

The registered person had not ensured staff were effectively deployed. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Recruitment files did not always contain all of the required information. Checks to ensure only suitable staff were employed were not always adequate.
● Some staff qualifications were not collected or missing from staff records.
The record of a staff member's criminal history check from the Disclosure and Barring Service was not available. Therefore, it was not possible to check whether they were safe to work with adults at risk.
● There were unexplained gaps in some staff's employment histories. A staff member's job history contained three different versions of one social care role they had worked in. One document stated they worked for one month at the other service, another stated from 2018 onwards and the related reference referred to five years' service and contained no employment dates. The conflicting information was not noted by the provider when the staff member started work and there was no explanation for the discrepancies or missing information in the staff member's file.
● Employment references for a staff member included information from another service's management as well as a colleague at the same service. These were not independent of each other. One document did not display the company or location name. One staff member declared they worked at another care location, but no evidence of conduct was requested from that employer as required. The service did not ensure they conducted sufficient checks of the employee's prior conduct.

The registered person had not ensured recruitment procedures were established and operated effectively to ensure only suitable staff were employed. They failed to ensure all information required in schedule 3 of the regulations was available. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager checked that all registered nurses were correctly registered with the Nursing and Midwifery Council. The provider's electronic system generated an alert when a nurse's registration was due to expire. The registered manager then ensured the nurse's registration was renewed in time.

Using medicines safely

● Staff did not follow best practice guidance to manage and administer people's medicines safely.
● One person had been prescribed paracetamol for pain. They were then prescribed co-dydramol to manage their increasing pain. The medication administration record clearly stated the two medicines were not to be given together, as they both contained paracetamol. Despite this, registered nurses and advanced healthcare practitioners had administered both the paracetamol and the co-dydramol together on eight separate occasions over three days before staff identified these medicines were being administered together and should not have been.
● For people living with diabetes and taking insulin to manage their blood sugar levels, staff monitored their blood glucose levels before giving them their insulin. However, staff did not quality check the blood glucose monitors according to the manufacturer's instructions. This meant the blood glucose reading may not have been accurate.
● Some people were prescribed medicines to be taken on a when required (PRN) basis. Guidance in the form of PRN protocols were not always in place to help staff give these medicines correctly.

The registered person did not ensure the proper and safe management of medicines. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● There was a lack of evidence to show staff were analysing incidents to look at why they were happening to prevent recurrences.
● Incidents were recorded in an electronic system which could be viewed by senior managers.
The registered manager confirmed there was no documented analysis of trends or themes for accidents and incidents.
● There was limited oversight from the regional manager and the provider's compliance team of all incidents and accidents logged at the service. They documented the number and type of incidents each month, for example falls, pressure ulcers or infections. However, they did not analyse the data they received to implement steps to identify causes and prevent recurrences.

The registered person failed to evaluate and improve their practice in respect of the processing of information related to accidents and incidents.
This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● Staff did not feel confident identifying safeguarding concerns. Staff completed safeguarding e-learning as part of their induction. Staff told us that safeguarding was not regularly discussed amongst the staff team in meetings, by senior management or during supervisions
● Safeguarding concerns were not always reported to the local authority promptly. A social care professional commented the registered manager had not notified them in a timely manner of safeguarding incidents which should be reported to the local authority.

We recommend that the provider ensures staff receive the necessary training and supervision to confidently identify and promptly act on safeguarding concerns.

Preventing and controlling infection
● We were somewhat 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 somewhat assured that the provider was using personal protective equipment effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks could 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.
● We have also signposted the provider to resources to develop their approach.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated 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; supporting people to eat and drink enough with choice in a balanced diet

- People's needs were not effectively assessed by staff.
- For example, wound care assessments and care plans were not detailed enough to enable staff to treat and monitor people's wounds effectively. Wound care plans did not contain sufficiently detailed descriptions of wounds and photographs to help staff monitor treatment and monitor healing.
- Another person's wound care plan stated the dressing should be changed every two to three days. There was no record to show that dressing changes had been completed on at least nine occasions when the dressing was due to be changed. We could not be assured people were receiving care which met their identified health needs.
- The home did not have a policy in place for managing people living with diabetes. In addition, care plans for people living with diabetes contained insufficient guidance for staff and inaccurate information. One person's care plan did not contain guidance for staff about how to help the person manage their condition. In addition, the care plan contained incorrect information about the person's condition. This section had been crossed out but not corrected with the accurate information. This put the person at risk of harm as staff did not use up to date and accurate information when delivering care and treatment.
- Staff used monitoring charts to track and manage one person's blood glucose levels. These had not been completed accurately and consistently. Blood glucose levels had not been re-checked after the person received their medicines. Blood glucose levels had not always been checked at the times specified in the person's care plan.
- Care plans did not always contain clear guidance for staff on how to manage people's oral health. One person wore dentures. Their care plan did not contain guidance about how staff should provide oral care for this person, such as denture cleaning and oral hygiene. We asked a staff member how this person's oral health should be managed. They told us, "I don't know". This put the person at risk of poor oral health due to staff not being aware of how to support them with their oral hygiene.
- One person was living with sleep apnoea, dementia and a chronic lung condition. The person's care documents did not contain any care plans to guide staff to manage these conditions. This put the person at risk of harm and unsafe care as staff did not have the specific guidance they needed to help manage the person's health conditions.
- Care plans for managing medicines for people with specific conditions were not always in place. For example, for one person who experienced seizures, there was no care plan in place. Also, for two people who were prescribed blood thinning medicines, there was no guidance in care documents for staff on how to monitor the person or manage the potential side effects.

● A person living with Parkinson's disease was prescribed medicines to be given at set times to manage their symptoms. There was no guidance for staff in their care plan about how vital it was to ensure Parkinson's medicines were given at equally spaced intervals.

The registered person had not effectively assessed and mitigated risks to the health and safety of service users. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's choices were not always met by staff.
● For example, the dining experience for people was poor.
● There was little interaction with people from staff.
There were periods of time when people were left with no interaction from staff. They often fell asleep in their wheelchairs and staff did not speak with or check on them.
● A dining room attendant and activities coordinator were in the dining room helping people with their meals. When other staff entered the room they only spoke with room attendant and activities coordinator and then left.
● Other staff asked if more people could sit in the conservatory adjoining the dining room but staff in the dining room stated they were too busy to support any more people. This conversation was loud enough to be heard above the music playing in the dining rooms and was held between staff across a table where people were sitting.
● Some staff helped people eat meals in their bedrooms. This meant they were not able to assist in the communal dining room. People experienced delays in having their meal served or being assisted to eat and drink in the dining room.
● Six people in wheelchairs were seated at the dining table an hour before the meal was served. Four of these people were left with no interaction from staff for more than 30 minutes. They slept in their wheelchairs whilst lunch was served. Bottles of wine were on the tables but people were seated for 30 minutes before staff offered them any.
● An agency staff member sat with a person but did not interact with them until they placed a piece of food in front of them. They did not speak to the person.
● Staff did not offer people choices of meals or confirm what they wanted. Meals were simply placed in front of people.

The registered person had failed to have regard to people's wellbeing when meeting their nutrition and hydration needs. This was a breach of Regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's risk of experiencing malnutrition or inadequate hydration was assessed by staff. Staff supported people to maintain a sufficient dietary intake.

Staff support: induction, training, skills and experience
● Staff did not receive the necessary training, supervision and support to help them safely meet people's needs.
● The registered manager stated there was a programme of supervisions and appraisals which included group and individual supervisions at regular intervals However, staff supervision records and the staff supervision matrix showed the programme was not being followed. The staff supervision matrix did not contain information about when staff supervisions were due. In addition, the matrix showed the most recent monthly staff supervision meetings were held in July 2021, none had taken place in August or September. The matrix showed staff had received group supervisions but only a few staff had received individual

supervisions.
● Supervision records did not identify development and training points for staff. They were used by the registered manager only as a way to highlight shortfalls in staff's practice.
● The deputy manager was a registered nurse who was responsible for overseeing the nursing team in the home. Their supervisions were completed by the registered manager who was not a nurse. The provider confirmed the deputy manager was not receiving any clinical supervision, which is a formal process of professional support and learning which enables qualified staff to develop professional knowledge and competence. This meant the provider was not arranging regular clinical supervision and support for the deputy manager to enable them to keep their practice and that of the nursing team up to date.
● Nursing staff were not suitably skilled to write clear plans of care and treatment for people with specific conditions For a person living with seizures, their care plan stated they had 'vague episodes'. The only action listed for staff was to keep the person's airway clear. The care plan did not use the correct terminology to describe the person's symptoms and contained insufficiently detailed actions for staff to keep the person safe. There was no evidence to show if the person had experienced seizures or if seizures were being monitored by staff.
● The deputy manager told us they had not received training from the provider in diabetes care. The staff training matrix showed staff had not been trained in this area. At the time of the inspection staff were providing care to people living with diabetes.
● One registered nurse said they did not understand diabetes. They added they did not know what to do if someone's blood sugar levels were too high or too low. This meant people with diabetes were at high risk of harm and/or complications from ill managed diabetes.
● Staff were not sufficiently skilled to safely support people living with diabetes.
● In another example, staff did not take action when a person's blood glucose levels increased to high levels and the person became seriously unwell. Only when they found the person to be unresponsive did they call the ambulance. Following their admission to hospital the person had died.

The registered person had not ensured staff were suitably qualified, competent, skilled and experienced to carry out their roles effectively. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered person had failed to assess risks to the health and safety of service users, do all that was reasonably practicable to mitigate these risks and ensure that persons providing care or treatment to service users had the qualifications, competence, skills and experience to do so safely. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
● In the provider information return dated October 2021, the registered manager documented that, 17 people were living with dementia. However, the environment was not suitable or appropriate for people living with dementia. The environment was not adapted to promote and encourage wellbeing and independence for people living with dementia.
● The regional manager stated no audits or assessments had been carried out to check the suitability of the environment for people living with dementia.
● There was insufficient dementia-friendly signage. Although there were some signs which contained words and pictures, for example depicting a bathroom, they were too small and, in some areas, hard to easily see. Recent guidance from the King's Fund, which is an independent charitable organisation working to improve health and care in England, states that signage is important for orientation. Signs using both images and text need to be placed at a height where they can easily be seen. Signs should be placed on

doors not beside them.
● The colour of walls, patterns of carpets, wallpaper and bathroom sanitary equipment had not been carefully considered to ensure people with dementia could distinguish different places and objects. Recent guidance states that "strong realistic patterns are likely to further disorientate people with dementia. Ensuring good colour contrast on sanitary fittings will make toilets and basins easier to see and use and promotes continence and personal hygiene."
● Storage space was very limited. Staff used communal spaces to place objects and items. For example, lateral flow tests were stored and administered in the hairdressing salon and people could not use the room as intended. Boxes of incontinence products were stacked in bathrooms, as well as wheelchairs and mobile hoists. Recent guidance from the King's Fund, explains that clutter and distractions can cause added confusion and should be avoided.

The registered person had failed to ensure the premises were suitable for people living with dementia. This was a breach of regulation 15 (premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's bedrooms were individualised, with their own items such as ornaments, pictures and other memorabilia.
● The premises were fully wheelchair accessible.
● There were two passengers lifts which made it easy for people with mobility impairments and others to move between floors.

Staff working with other agencies to provide consistent, effective, timely care; supporting people to live healthier lives, access healthcare services and support
Staff did not always work effectively with other agencies to provide effective support and promote people's health and wellbeing.
A health professional commented that staff did not always follow guidance from other agencies to help meet people's social and psychological needs.

We recommend the registered person review's staff practice to ensure they work effectively with professionals to meet people's health and wellbeing needs.

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.

● Some people lacked the capacity to consent to care and treatment. Care plans lacked evidence of decisions made in people's 'best interests' regarding their care and treatment. For example, one person was given medicines covertly, as they lacked the capacity to make a decision about this aspect of their care. The person's care plan did not contain evidence of a best interest decision process involving the appropriate professionals and the person's legally appointed representative.
● In two people's care records staff had stated they lacked capacity and had a legally appointed representative acting on their behalf to make decisions regarding their health and welfare. There was no evidence of legal documentation to support this. In addition, there was no evidence that meetings had been held between the people's legally appointed representatives, relevant professionals and staff.
● In another person's care record it stated they lived with a condition which meant they were able to understand what was said to them but they were unable to communicate verbally. Their care plan did not contain evidence of decisions agreed with the person or how the person had communicated their consent.

The registered person had failed to keep complete and accurate records of consent and decisions made by people or on their behalf in their best interests. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Systems were in place to monitor DoLS applications and authorisations and to ensure conditions were met.

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 were not always well treated and supported appropriately
- People told us they were reluctant to drink because if they needed to go to the toilet staff would not be able to assist them in time. One person said, "I do get plenty of drink but if I have too much I need to go to the [toilet] and I have to wait for carers to come to help me. I panic sometimes and thus it goes around and becomes a vicious circle. I need to drink but then I need to go to toilet and I need help".
- People's privacy, dignity and independence were not always promoted and upheld.
- During the inspection two people who were incontinent were not assisted to change by staff until just before lunch was served. They had been left wet all morning.
- People were not supported to maintain their independence. One person told us: "I can walk with my [walking frame] but they leave it by my bathroom and I can't get to it, so if I want anything, say something from my drawers I have to ring the bell."
- During busier periods, when staff had begun to support people to wash and dress, staff were called to assist other people. During the inspection a person needed help to be repositioned in their bed. The housekeeper asked one of the two care staff attending another person to attend to this person. The person the two staff members had already started assisting then had to wait for the staff member to return so their personal care could be completed.

The registered person had not supported people's dignity, autonomy and independence. This is a breach of Regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We observed staff treating people with compassion during group activities. People were supported to engage in themed activities such as quizzes and painting. The activities coordinator was engaging and enthusiastic as they supported people to take part in these activities.
- One person commented on the caring attitude of staff. They said "The service I get here is second to none."

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

- People were not supported to express their views or be involved in making decisions about their care
- There was a lack of evidence to show the provider sought regular feedback from people using the service. We saw evidence of one quality assurance survey regarding people's experience of care and support had

been completed with people's relatives. However, there was no evidence to show actions were taken following completion of surveys, or of any further surveys which were scheduled.

We recommend the registered person establishes an effective system to enable them to seek and act on feedback from people using the service and other relevant persons.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement: This meant people's needs were not always met.

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

- People were not involved in planning their care and support. People commented they were not aware of what was written in their care plans. There was also a lack of evidence in people's care documents that they had been involved in reviews of their care and support needs.
- Care plans did not reflect how people's health conditions impacted on their daily lives, or the type and level of support they needed. People's strengths, levels of independence and quality of life were also not reflected. There was a lack of significant and relevant information about people's personal history, individual preferences, interests, hobbies or aspirations. This meant this information was not available to staff to help them plan individualised care and support.
- People did not always receive individualised or appropriate care and support at the end of their lives. Care records did not detail the development of illness or how end of life care had been planned for in a way that ensured personal needs and preferences at the end of their lives had been considered fully with the help of family, friends, advocates or support workers. Care plans were task focused and contained basic information about their medical needs, funeral arrangements and whether the person should be admitted to hospital. However, care plans lacked specific details about people's spiritual, cultural and emotional needs.

The registered person had not provided appropriate care which met people's needs and preferences. This was a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

- The provider did not maintain an accurate and up to date record of complaints and concerns.
- For all complaints logged there were no records of the initial complaint, or of the investigation undertaken to address the complaint. The log contained outcome responses only. This meant it was not possible to see the full actions taken by the registered manager to address and investigate people's concerns and complaints.
- A relative told us they were dissatisfied with the registered manager's response when their loved one's possession went missing. The registered manager admitted they had not made a record of the person's belongings when they moved to the home. The relative told us they were unhappy with the outcome and the registered manager's response. They felt they had not been offered a sufficient explanation for the lost item.

The registered person had not established and operated effectively an accessible system for identifying,

receiving, recording, handling and responding to complaints by service users and other persons. This was a breach of regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- There was a lack of leadership and oversight of the service was not adequate.
- Although there were a number of audits and quality assurance systems in place they were not effectively operated.
- The registered manager told us there was an action plan for the service which was regularly updated and had been generated as a result of their audit programme. We requested documentary evidence of this. The registered manager sent us a spreadsheet which detailed actions, the name of the staff member responsible for their completion and whether the action had been completed. Several of the actions for the registered manager were overdue, including staff training for wound care management and staff training in diabetes care. In addition, the safety concerns and issues identified during the inspection had not been identified. It was not clear from the action plan who retained the overall responsibility for its monitoring and completion, as the names of the registered manager and several managers were included within it. When questioned the registered manager was not able to explain how the action plan was being used to assess, monitor and improve safety in the service.
- Systems did not enable the registered manager and provider to identify where they were not meeting their legal obligations and the fundamental standards.
- People did not receive person centred care and systems and processes to monitor care delivery were not effective. Staff were not deployed effectively to provide person-centred care and people's dignity, independence and human rights were not protected by staff.

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; continuous learning and improving care; working in partnership with others

- The culture was not person-centred. The registered manager did not promote an open, inclusive and empowering culture in the service.
- Staff were not supported to develop their practice to provide individualised care. One staff member stated they found it difficult to communicate with people who had suffered a stroke. They commented they would like training in this area.
- People, staff and the public were not always involved in how the service was run.
- The registered manager was unable to demonstrate how the views and experiences of people were explored and how involvement in their care was promoted. There were no arrangements in place to show how comments or concerns received from people were considered or managed to drive improvement.

● Meetings were held with people by the registered manager. Although some of people's questions about the service were answered, there was no evidence to show staff were identifying actions from meetings and following up on these. There were records for only two meetings over the last 12 months.
● Staff meetings were used by the registered manager as an opportunity to communicate messages with staff and highlight shortfalls in staff practice. There was no evidence to show staff were encouraged to give feedback or to influence how the service was run.
● There was a lack of evidence to show the registered manager encouraged and supported staff to reflect on practice to make improvements to the service to provide individualised, safe and effective care.
● Staff did not always work effectively in partnership with professionals from health and social care to promote people's health and wellbeing.
● Professionals we spoke with commented the provider, registered manager and staff did not always follow guidance from professionals working for different agencies to meet people's social and psychological needs.

● Another professional commented that the provider was not open and transparent in their communication with outside agencies and had not sought timely healthcare advice to ensure people's safety and wellbeing.

The registered person had not established an effective system to enable them to ensure compliance with their legal obligations and the regulations. The registered person had not assessed, monitored and mitigated the risks relating to the health, safety and welfare of service users. The registered person had not sought and acted on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services. The registered person had not evaluated and improved their practice. These areas are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care How the regulation was not being met The registered person had not provided appropriate care which met people's needs and preferences. Regulation 9 (1)(a)(b)(3)(i)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect How the regulation was not being met The registered person had not supported people's dignity, autonomy and independence. Regulation 10 (1)(2)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent How the regulation was not being met The registered person had failed to ensure service user's consent was appropriately sought and recorded in relation to care and treatment. Regulation 11 (1)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 15 HSCA RA Regulations 2014

personal care Treatment of disease, disorder or injury	Premises and equipment How the regulation was not being met The registered person had failed to ensure the premises were suitable for the purpose for which they were being used in relation to their suitability for people living with dementia. Regulation 15 (1)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints How the regulation was not being met The registered person had not established and operated effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons. Regulation 16 (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed How the regulation was not being met The registered person had not ensured recruitment procedures were established and operated effectively to ensure only suitable staff were employed. The registered person had failed to ensure the information specified in Schedule 3 of the regulations was available. Regulation 19 (2)(3)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing How the regulation was not being met The registered person had not ensured sufficient numbers of suitably qualified, competent, skilled and experienced staff were

deployed.
Staff did not receive appropriate support, training, professional development and supervision to enable them to carry out the duties they are employed to perform.
Regulation 18 (1)(2)(a)

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met The registered person had not ensured risks to the health and safety of service users were effectively assessed and mitigated. The registered person did not ensure the proper and safe management of medicines. Regulation 12 (1)(2)(a)(b)(g)

The enforcement action we took:

We served a warning notice on the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance How the regulation was not being met The registered person had not established an effective system to enable them to ensure compliance with their legal obligations and the regulations. The registered person had not assessed, monitored and mitigated the risks relating to the health, safety and welfare of service users. The registered person had not sought and acted on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services. The registered person had not evaluated and improved their practice. Regulation 17 (1)(2)(a)(b)(e)(f)

The enforcement action we took:

We served a warning notice on the provider.