Sweet Homes Limited (A Joshi)

Sweet Homes Limited t/a Carshalton Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Inadequate**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Sweet Homes Limited t/a Carshalton Nursing Home is a care home providing accommodation, personal care and nursing to people over 65. The care home is registered to accommodate up to 33 people in one building on a residential road. At the time of our inspection 15 people were living there.

People's experience of using this service and what we found
People were at risk of avoidable harm. The provider failed to ensure the environment was always safe for people. We found cables dangling above the pillows on people's beds creating a risk of strangulation. We found windows which were not restricted which meant people could fall from them. We also found water running at temperatures hot enough to scald and burn.

The provider failed to assess, monitor and mitigate known risks. People presenting with known risks such as those associated with falling and catheter use did not have risk assessments or detailed care plans in place. This meant staff did not have guidance about keeping people safe.

Poor hygiene practices put people at risk of infection. Clinical waste bins which were used for the disposal of soiled incontinence pads had missing and ill-fitting bags. People were not encouraged to wash their hands and we found toilets without soap and hand towels.

People were at risk of not receiving their medicine as prescribed. We found medicine on the floor in the communal area of the care home, an overstocked medicines room and the improper signing of medicines records.

The provider did not always work in partnership with others to reduce risks to people. Due to the concerns regarding nursing practices at the service, the local clinical commissioning group offered to provide a nurse to oversee nursing and medicines practices at the service. The provider refused to cooperate with this, despite their failure to identify and address the nursing failings we found.

The premises was not properly maintained. The décor in some people's bedrooms was unpleasant. We found bare, stained walls and dusty dry sinks. These rooms were not homely and could not contribute to people's mental well-being.

People were bored and unstimulated. People did not leave the care home. No activities were provided in the community and people had access to only one room for the entirety of each day. This was the day room where people did very little besides eat their meals and watch an exercise video.

People were not always well cared for. Staff did not brush people's teeth and their oral hygiene suffered as a result. We observed that staff did not always speak to people in a caring and respectful way.

The provider's quality assurance processes were inadequate. The service remained in breach of five regulations we found them to be in breach of in 2019. Quality checks did not reveal the significant failings we found in the safety of the environment; management of risk; administration of medicines; detail in care records and people's quality of life.

We found staff were recruited through safe procedures and received supervision, appraisal and training. Timely referrals were made to healthcare professionals.

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 10 October 2019). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection 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 people's care, medicines, infection control and the care home environment. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. The overall rating for the service has changed from Requires Improvement to Inadequate. This is based on the findings at this inspection. You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We have identified breaches in relation to safe care and treatment, the premises, person centred care, people's dignity and the provider's governance.

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

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not always 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.

Sweet Homes Limited t/a Carshalton Nursing Home

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by three inspectors.

Service and service type
Sweet Homes Limited t/a Carshalton Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as 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. Inspection activity started on 30 September 2021 and ended on 4 October 2021. We visited the location on both dates.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they

plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with seven people about their experience of the care provided. We spoke with two members of staff and the registered manager. We reviewed a range of records. These included eight people's care records and three 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 attended a meeting for professionals who regularly visit the service.

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

● People were at risk of strangulation. We found wall mounted lamps above people's beds with dangling cables close to their pillows. People risked becoming entangled in these leads whilst in bed. The provider failed to assess or mitigate the risks of accidental strangulation or deliberate self-harm at ligature points. We had to insist these dangers were removed before we finished our inspection. The provider did this.

● The provider failed to maintain a safe environment for people. Windows in people's bedrooms lacked adequate restrictors. We found bedroom windows without restrictors, rusting restrictors and restrictors which were not attached. This meant people were at risk of falling from height.

● People were at risk of being scalded by hot water. We checked the water temperature from taps in people's bedroom sinks. We found temperatures in people's bedrooms exceeded 50 degrees. This temperature is hot enough to burn skin and hotter than permitted in published guidance. The provider had placed signs above people's sinks stating, "very hot water." This measure was insufficient to protect people who could experience dementia-related disorientation or poor vision from being scalded. The provider failed to regularly monitor water temperatures or introduce measures such as thermostatic controls to mitigate the risk of avoidable harm.

● People were at further risk of burn injuries because they could access areas which should have been secured. On the first day of our inspection we noted that a maintenance cupboard on the second floor was unlocked and wide open exposing its hot pipes. This presented a risk of people sustaining burn injuries. We informed the registered manager. On the second day of our inspection we found the cupboard still open and the risk on-going. We were required to insist that this door was closed and locked to protect people from foreseeable harm. The provider did this.

● The provider impeded people from summoning help if they fell whilst in communal toilets and bathrooms. We found communal bathrooms and toilets where emergency cords had been tied up or were missing altogether. The practice of tying up emergency cords meant if a person fell, they would be unable to reach the cord to summon help.

● On the first day of our inspection we observed that the call bell panel was lit up for one person's bedroom. This indicated a person had activated it. For the reminder of that day the call bell panel remained lit for this person's bedroom. This was because staff hadn't deactivated it. The registered manager and staff were unable to explain how they would know if the person in this room needed help again before they reset the panel.

● People's risk of falling was not adequately managed. We found two people with assessments describing them as being at medium risk of falls. However, there was no information in their care records describing the actions to be taken by staff to mitigate this risk. This meant staff did not have sufficient guidance to protect people from known risks.

● People's risk of malnutrition was not always mitigated. We found two people who did not have their nutritional needs assessed. This meant staff did not have information regarding the support people required to eat safely and sufficiently.

The provider's failure to adequately assess the risks to the health and safety of people, to mitigate risks and ensure that the premises used are safe is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

Using medicines safely
At our last comprehensive inspection, we found medicines were not always managed safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

At this inspection we found poor medicines management. The provider remained in breach of Regulation 12.

● Prior to our inspection healthcare professionals had alerted us to concerns regarding people's medicines. This included concerns about medicines storage and finding people's medicine on the floor. At our inspection we also found medicine on the floor. Staff we spoke with were unable to identify the two tablets we found, did not know to whom they were supposed to have been administered or for how long the medicine had been on the floor. This meant people were at risk of not receiving their medicine as prescribed and of receiving medicine prescribed for someone else if they picked it up.
● We reviewed people's medicines administration records (MAR). We found one person's MAR chart had not been signed. We pointed this out to a nurse who took the MAR chart and signed it. This practice is not in line with guidance. Staff should sign people's MAR charts one at a time and immediately after administering medicine to them. A deviation from this practice risks the member of staff administrating medicines being distracted and as a result making an error.
● The medicines storage room was overstocked. We found plastic bags containing blister packs full of medicine which should have been returned to the pharmacist. We also saw boxes of unused food supplements similarly piled up. The poor storage of medicines increases the risk of medicines errors.

The failure to ensure the proper and safe management of medicines is an additional breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

Preventing and controlling infection
● People were not adequately protected from the risk and spread of infection because the provider failed to consistently maintain a hygienic environment.
● Two days before our inspection Local Authority staff forwarded photographs to CQC showing poor hygiene practices at the service. Images included a soiled incontinence pad in a communal bathroom sink.
● We checked communal bathrooms to review the provider's practice for the disposal of clinical waste. In one communal bathroom we found a clinical waste bin without a clinical waste bag. This meant there was no barrier between the bin and soiled items dropped into it. In another communal bathroom we found a clinical waste bin with a clinical waste bag which did not fit and was hanging off as a result. The clinical waste bin could not be used without first touching the ill-fitting bag to hold it open. This meant people, visitors and staff were exposed to the risk of and spread of infection.
● The provider did not promote a hand washing culture. We observed people having lunch. We noted staff did not offer to support people to wash their hands before eating. Instead we saw people having to pass a packet of hand wipes around to each other before eating. This practice did not involve staff.

● We checked communal toilets to see how regular hand washing was supported. In one communal bathroom there was no soap in the wall-mounted dispenser which meant people could not effectively wash their hands. In another communal toilet there was no wastepaper bin. This had the potential to discourage people from washing their hands.

The provider's failure to assess, prevent, detect and control the spread of infections, including those that are healthcare associated, is a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

Learning lessons when things go wrong

● The provider did not learn lessons when shortfalls were brought to their attention. For example, at our last comprehensive inspection we reported that the provider's nurses failed to maintain fluid balance charts for people who used catheters. Two days before our inspection healthcare professionals working with the local authority found continued failure by the provider to maintain fluid balance records. We were concerned because these charts record the fluids that people with catheters consume and pass. Fluid balance charts are used to manage people's risks of dehydration and urine retention.

The providers' failure to monitor and improve the quality and safety of the service is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

Systems and processes to safeguard people from the risk of abuse

● The provider had safeguarding policies and procedures in place. However, we could not be assured that all of the staff understood these. When we asked staff how they might recognise signs that people may be at risk of neglect and what they would do about it, their responses varied. For example, one member of staff told us they would bring it to the attention of a nurse or the registered manager, another member of staff did not know what neglect meant.

● Similarly, the provider had policies and procedures in place regarding whistleblowing, but staff understanding was mixed. For example, one member of staff told us they did not know what whistleblowing was whilst another member of staff did.

● The registered manager understood the provider's safeguarding responsibilities and their responsibility to report safeguarding concerns to both the local authority and CQC.

Staffing and recruitment

● The provider followed robust procedures when recruiting staff. This included obtaining employment histories and references to verify these. Staff were interviewed and their identities were confirmed. Checks were made against criminal records data bases and the registration status of nurses was confirmed.

● The registered manager ensured that the staffing numbers rostered to deliver care were sufficient to meet people's needs.

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.

Adapting service, design, decoration to meet people's needs
At out last comprehensive inspection we found the care home had been insufficiently adapted to meet people's needs. This was because baths were not fit for purpose, people had access to only one communal area and the décor was tired and worn. This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Premises and equipment.

At this inspection we found not enough improvement had been made and the service remained in breach of Regulation 15.

● At our last comprehensive inspection, we found people were unable to use the baths in the communal bathrooms because hoists could not be safely used. At this inspection we found the provider had replaced unusable baths with showers. However, the showers installed did not have thermostatic mixing valves which could restrict water temperature. Instead the showers had manual settings which enabled the water temperature to run at 50 degrees centigrade. This meant people were at risk of being accidently scalded by staff when receiving personal care.
● People continued to have access to only one communal area. This was the lounge/day room. No other areas of the care home had been adapted for people to use. For example, there was no quiet room, activities room, TV room or dining room. This meant if people chose to leave their bedrooms, they had to spend all their time in the day room.
● Décor in parts of the care home remained poor. Some people's bedrooms had significant staining on bare walls and dusty, dry sinks. Doors were chipped and scuffed. In one person's bedroom we saw a bucket of brown liquid in the middle of the floor.

The failure to properly maintain, keep clean and secure premises which are suitable is a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Premises and equipment.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were not always appropriately assessed. One person's care records contained very little information about their mobility, continence and nutrition needs despite their risk of falls, catheterisation and malnutrition. This meant staff did not have the guidance they needed to meet people's needs effectively.
● People's assessments did not always reflect their choices. We found care records which did not state people's likes, dislikes or any personal history. This meant staff did not always have the information they

required to provide effective, personalised care and support.

The failure to provide care and support to meet people's needs or reflect their preferences is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person centred care. Further details regarding this regulatory breach can be seen in the Responsive section of this report.

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

● People were not always supported to live healthier lives. The provider failed to effectively meet people's oral hygiene needs. We found people were not supported to brush their teeth. This meant they were at risk of infection and gum disease. Further information regarding the provider's failure to support people's dental health can be read in the Caring section of this report.

● Where people required access to healthcare services the registered manager ensured timely referrals were made.

● Staff supported people to attend appointments with healthcare professionals at the service.

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

● We found a mixed picture regarding how people's nutrition and hydration needs were met. Permanent residents of the service had their nutritional needs assessed and met. However, people receiving respite care did not always have their nutritional needs assessed. This meant staff did not have guidance in care records detailing the support people required to eat safely. We explain the risks resulting from this failing in the Safe section of this report.

● Throughout our inspection we observed that people had drinks within reach at all times. Jugs of squash and water were placed on the tables around the room. This meant people had a choice of drinks and could remain hydrated throughout the day.

Staff support: induction, training, skills and experience

● Staff received an induction when they joined the service. This orientated them to people, the environment of the home and the procedures for delivering care.

● The registered manager provided staff with one to one supervision meetings. These were used to discuss people's changing needs and the personal development of staff.

● Staff received planned and on-going training. This included in areas such as moving and handling, supporting people living with dementia and end of life care.

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.

● People's mental capacity was assessed, and they were treated in line with legislation.

● Where people were deprived of the liberty in order to keep them safe, the nature of the restriction and the duration of its authorisation was clearly stated.

Inadequate

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 Requires Improvement. At this inspection this key question has deteriorated to Inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

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

At our last inspection we found people did not always feel well-supported, cared for or treated with dignity and respect. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Dignity and respect.

At this inspection we found insufficient improvements had been made and the provider remained in breach of Regulation 10

● People were not always well treated. Prior to our inspection healthcare professionals alerted us to the risk that people's oral hygiene needs were not being met. During the inspection and with people's consent we checked using tissue paper to see if toothbrushes were wet. The toothbrushes were dry. This meant they had not been used to brush people's teeth that day.
● People were not receiving support to brush their teeth. We spoke with people who had a visible build-up of plaque. One person told us their teeth had not been brushed since they moved into the service. With their permission we checked their bedroom. They did not have a toothbrush or any toothpaste. This meant they were at risk of further tooth decay and potentially pain.
● People's dignity was not always protected. We met with one person who told us the clothes they were wearing were not their own. We observed that when walking to the toilet this person needed to hold onto both sides of their oversized trousers to prevent the indignity of them falling down in front of other people.
● Staff did not always speak to people in a respectful manner. On the first day of our inspection one of our inspectors entered the day room/lounge area. We observed the member of staff arguing with one person before raising their voice to declare, "That's enough, be quiet." This interaction did not convey respect for the person.
● Staff did not always treat people in a respectful way. We observed the lunchtime period and saw staff approaching people and placing aprons on them without talking to people or asking them whether they wanted an apron or not.
● People's privacy was not always respected. On both days of our inspection we saw the Medicine Administration Records folder left on top of the medicines trolley in the communal area. There was a risk the contents could be viewed by individuals not authorised to see them. This meant the provider failed to assure the privacy of people's confidential health information.

The failure to treat people with dignity and respect is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Dignity and respect.

● Notwithstanding our observations people were complimentary about staff and registered manager. One person said, "They [staff] are very good." Referring to the registered manager, one person described them as, "A lovely lady."
● We observed staff respecting people's dignity around toilet use. We saw staff discreetly asking people if they needed to use the toilet and supporting them to do so.
● People were supported around their cultural and spiritual needs. Prior to the pandemic the service had been visited by a Church of England vicar and a Catholic priest. Since that time people had been supported to participate in religious services virtually. This meant people continued to be supported to practice their faith.
● People were supported to participate in days of cultural and religious significance to them such as Christmas, Easter and Remembrance Sunday.
● People from another European country were assisted by staff to listen to music in their language.

Supporting people to express their views and be involved in making decisions about their care
● People made some decisions about how they received their care. For example, we saw staff offering people choices around what they ate and drank. However, people had very little choice regarding other areas of their care and support such as the activities they engaged in.
● To maintain their independence with drinking some people used double handed cups. This meant they were not dependent on staff assistance to hold a drink.

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.

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

At our last comprehensive inspection, we found people did not receive personalised care. There was a lack of stimulating activities for people and their bedrooms were not personalised. The failure to design care with a view to people's preferences and meeting their needs was a breach of Regulation 9 (1) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care.

At this inspection we found insufficient improvements had been made and the provider remained in breach of regulation 9.

● People were bored and unstimulated. Besides a daily exercise video there was very little for people to do. One person told us, "We don't do much." Another person told us they preferred to stay in their bedroom because in the communal area, "It is very monotonous".
● People had access to a single communal area. They sat in the lounge/day room all day and dined there too. No rooms within the care home had been set aside for people to use as a quiet space, to engage in activities, to eat meals or watch television. People's only alternative was to remain alone in their bedrooms if they did not want to be in the communal day room. This meant people continued to have little choice over where they spent their time.
● People told us they never left the care home for activities or a change of scenery. One person told us, "I can't remember the last time I went out. I would just like to." This meant people were not supported to participate in their local community.
● Whilst some people had person centred plans others did not. This meant staff did not always have information regarding people's likes and dislikes and their preferences for how they wanted to receive care and support.
● Similarly, whilst some people had personalised bedrooms which contained framed photographs of family members, mementos, soft toys and personal items on display others did not. Rooms which were not personalised were bleak. For example, one person's bedroom had no personal effects on display at all. Their bedroom walls were poorly painted and heavily stained. A large plastic paper towel dispenser of the type used in public toilets was fixed to their wall. This made their bedroom look institutional rather than personalised. Their sink was blocked and out of use. Their bedroom door was markedly scratched and chipped. No attempt had been made to make the room homely to support the person's well-being.

The failure to provide care and support to meet people's needs or reflect their preferences is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person centred

care.

Improving care quality in response to complaints or concerns
At our last comprehensive inspection, we found people did not know how to make a complaint because information was not available to them. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Complaints.

At this inspection we found that sufficient improvements had been made and the provider was no longer in breach of regulation 16.

● People we spoke with understood how to make a complaint and told us how they would do so if they were dissatisfied with their care and support.
● The provider made information available to people explaining how they could make a complaint if they were unhappy with any aspect of their care and support.
● The registered manager understood their role and responsibility to investigate and respond to all complaints.

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 had access to large font and pictorial information to assist their understanding of printed information

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● People were supported to maintain the relationships that were important to them. Relatives visited people and were encouraged to phone the service for updates.
● The provider kept relatives informed about events at the service as well as their family member's well-being.
● The provider recognised people's cultural needs and sourced both music and films for people in their first language.

End of life care and support
● None of the people receiving care and support had been identified as requiring end of life care at the time of our inspection.
● The registered manager knew which healthcare professionals to refer people to should people be identified as requiring end of life care.

Inadequate

Is the service well-led?

Our findings

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

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

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

At our last comprehensive inspection we found the provider failed to assess, monitor and improve the quality of the service; to maintain accurate and complete care records and rectify shortfalls. This was a breach of Regulation 17 the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance.

At this inspection we found that insufficient improvements had been made and the provider remained in breach of Regulation 17.

● The provider demonstrated inadequate governance. The failure of leadership was evident in the provider's repeated breach of five regulations we reported about following our last comprehensive inspection two years ago.
● The provider's quality assurance processes were inadequate because they failed to identify people's risk of avoidable harm or to make the improvements required to mitigate these risks. For example, the provider failed to identify people's risks of being scalded by hot water or take the reasonable, practical and necessary step of restricting water temperature. Additionally, the provider failed to routinely check water temperatures. Maintenance audits showed the provider had not carried out any water temperature checks for the month before our inspection.
● Similarly, the provider failed to regularly check windows throughout the property. As a result, the provider did not know window restrictors were missing and rusty. This meant people were at risk of falling from height because the provider failed to conduct appropriate safety checks and make improvements.
● The provider's quality assurances processes failed to identify and rectify hygiene failures. These included the unsanitary use of clinical waste bins and inadequate support for hand hygiene.
● The provider failed to act on previously highlighted failings. For example, at our last comprehensive inspection we reported that people were unstimulated with very little to do. At this inspection people remained bored, confined to one communal day room, had minimal structured activity and never left the care home for recreation.
● Poor leadership oversight resulted in the inadequate medicines management practices we found. These included medicines on the floor, unsigned medicines records and a cluttered medicines storage room.
● The impact of inadequate management was most acutely felt by people receiving respite care. We found

people living temporarily at the service without proper assessments or care plans in place to cover important areas such as falls prevention, malnutrition and catheter care. This meant people were at risk of avoidable harm.

The failure to assess, monitor and improve the quality and safety of the service is a breach of Regulation 17 the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance.

Working in partnership with others

● The provider did not always work in partnership with others. For example, following the quality assurance visits by health and social care professionals that triggered our inspection, assistance was offered to the service by the local clinical commissioning group (CCG). The CCG arranged for a nurse to oversee clinical practices at the service. The provider rejected this offer of help. We were concerned that the provider rejected the involvement of a competent nurse because of the nature and volume of concerns around nursing practices found at the service.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The registered manager understood their duty of candour and their responsibility to be open with people when things had gone wrong. For example, following our last comprehensive inspection the registered manager held a meeting for people and their relatives to discuss the concerns we raised in our report.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

● The provider gathered people's views in surveys. The registered manager reviewed people's responses and acted upon them. For example, changes were made to the menu in relation to the food preferences people expressed.

● The registered manager arranged team meetings for care staff and nurses to attend. These quarterly meetings were used to discuss care and support and changes to be made. Minutes were made of these meetings for later review and for staff who could not attend.

● Prior to the pandemic the registered manager arranged meetings for relatives to attend and planned to restart these in the future. As an interim measure the views of relatives were gathered on an individual basis.