Marula Lodge Limited

Marula Lodge

Inspection report

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Date of inspection visit:
21 October 2021

Date of publication:
25 January 2022

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?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Marula Lodge is a nursing home. The service provides personal and nursing care for up to 42 people with complex needs including distressed behaviours related to dementia and mental health needs. At the time of the inspection there were 15 people living at the service.

People's experience of using this service and what we found

People were not always protected against risks associated with their care. The environment and equipment was not set up to meet the complex needs of people. The local authority were not always being informed when safeguarding incidents occurred. The care people received was restrictive and people were not always being protected from the risk of abuse.

Accidents, behaviours and incidents were not always recorded in sufficient detail, and not enough action was taken to reduce further risks to people.

Staff were not deployed effectively to ensure that people received their care when needed and there was a lack of training specific to the needs of people. Supervisions with staff were not effective in identifying shortfalls. The provider did not have appropriate systems in place to review the level of individual needs of people to ensure sufficient staff were on duty.

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 were not always supported with their independence and there were times when staff were not as kind and attentive as they should have been.

The provider failed to ensure there was robust auditing to review the quality of care. Notifications were not always being sent to the CQC where it was appropriate to do so.

We did see instances where staff were caring and understood how to support people who were anxious. People were supported with hydration and relatives fed back that people enjoyed the food. People had access to support from visiting healthcare professionals.

Rating at last inspection
This service was registered with us on 6 May 2021 and this is the first inspection.

Why we inspected

The inspection was prompted in part due to concerns received about the staff levels at the service, staff unlawfully restraining people and the dementia environment not suiting the needs of people. A decision was

made for us to inspect and examine those risks.

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 provider has provided us with assurances they will not be admitting people to the service until improvements have been made.

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

We have identified breaches in relation to the deployment and training of staff, people not being protected against the risk of unlawful restraint and abuse, the principles of the mental capacity act not being applied, risks associated with people's care not being managed in a safe way, lack of meaningful activities for people, the environment not being set up to meet people's needs and lack of robust provider oversight of the quality and safety of care at this inspection.

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 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.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Marula Lodge

Detailed findings

Background to this inspection

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

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

Inspection team
Our inspection was completed by two inspectors.

Service and service type
Marula Lodge 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 had received about the service since the last inspection. We were provided feedback from the local authority and healthcare professionals who work with the service. We reviewed the provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We

used all of this information to plan our inspection.

During the inspection
We spoke with two relatives about their experience of the care provided. We spoke with 10 members of staff including the provider, registered manager, members of the providers senior management team, care workers, a housekeeper and the chef. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We reviewed a range of records. This included two people's care records and multiple medicines records.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at six care plans, pre-admissions assessments, training data, quality assurance records, recruitment files for five members of staff and staff supervision. A variety of records relating to the management of the service, including policies and procedures were also reviewed. We spoke with two professionals who regularly visited the service and with one relative of a person receiving care.

Inadequate

Is the service safe?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

● People were not protected from unlawful restraint. Prior to the inspection three health care professionals fed back to us they had observed people being restrained by staff including staff stopping one person from walking by using a moving and handling equipment and another person being locked in their room with a member of staff to prevent them from leaving. Although they raised this with the registered manager and had raised this as a safeguarding concern with the local authority, we found people were still being restrained at the inspection.

● There were three people at the service that were at risk of falls but were able to walk with support from staff. All three had their bed in a floor low position and were unable to swing their legs over the edge of the bed and stand up. Staff were not supporting these people to walk with them, instead encouraging them to stay in their beds. We observed one person being held by their arms in bed to stop them from getting up. The registered manager told us they were reviewing the use of the 'floor beds' as they also had concerns about the common use of such equipment for people at high risk of falls without exploring other less restrictive options.

● The provider and registered manager had failed to understand their responsibility to report all safeguarding concerns to the local authority. There were three safeguarding incidents that had been notified to the CQC, but the local authority confirmed they had not been notified to them as required. On review of the incidents of behaviours at the service, there were a further two safeguarding concerns that had not been reported to the local authority. These both included physical assaults from one person to another. This was despite the safeguarding policy being clear on when incidents needed to be reported.

● Although staff received safeguarding training, when asked staff did not always know who they needed to contact outside of the service if they suspected abuse. One told us, "I don't know the contacts for safeguarding are. I would go to seniors."

As the provider failed to report safeguarding incidents where appropriate to safeguard people from the risk of abuse and improper treatment and people were being unlawfully restrained this was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

●Risks associated with people's care were not always managed in a safe way. Staff told us one person threw objects including mugs which put other people at risk and as result the kitchen cupboards were kept locked. A member of staff told us, "(Person) could throw cups when distressed." They told us the person had also thrown two dining tables and some chairs. This risk was not mentioned in the person's care plan.

● According to their care plan another person was admitted to the service as being at high risk of malnutrition. The food and fluid monitoring was not adequate and did not contain details of the amount of

food and fluids people received. When asked, the registered manager told us only one person was losing weight due to their declining health and no other people were at risk of malnutrition. After the inspection we asked the registered manager when the person was last weighed, and they told us this person had in fact lost weight two weeks prior to our inspection. They told us they were now going to introduce weekly weights for the person. According to their care plan another person was required to be weighed weekly. However, this was not taking place.

● The risks associated with people's behaviours and the strategies to manage this were not always clear in people's care plans. For example, according to their care records one person had over 100 incidents of behaviour over an eight-week period. There was no detailed guidance on how best to support the person with their behaviours in this person's care plan.

● People's behaviours were not formally recorded allowing a robust analysis of any triggers, for example with use of an ABC chart. An ABC chart is a direct observation tool that can be used to collect information about the events that are occurring within a person's environment. Staff were required to record when people displayed a distressed behaviour within their daily care notes. We observed a person have challenging behaviour during the morning of the inspection. The notes recorded by staff about this just referenced to the person being 'Restless' and '"Agitated' with no further detail. There was no information on what led up to the behaviour, details of how the person was behaving or what support was provided to try and manage this. This information could be used to identify patterns of behaviour and subsequently develop effective management strategies.

● The providers PIR stated, "Our priority is understanding antecedents to challenging behaviours and addressing these at an early stage." However, we found this was not always taking place due to the lack of formal recording and analysis of people's behaviours.

The failure to not always manage risks associated with people's care in a safe way was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Relatives did feedback they had observed staff supported people around their distressed behaviours in a safe way. One told us, "Staff are handling it really well, know how to de-escalate, they are getting it right."

● There were elements to the management of risk that were managed in a safe way. Where clinical risks were identified appropriate plans were in place to reduce the risks to people. likelihood of them occurring for example with wound care.

● There were adequate number and selection of moving and handling equipment to assist staff to support the people requiring transfer that had been regularly serviced.

● Equipment was available to assist in the evacuation of people. Fire exits were clearly marked and free from obstruction and fire evacuation plans were displayed throughout.

Staffing and recruitment

● Staff were not deployed effectively around the service to ensure people's safety. Relatives fed back to us about staff deployment and numbers of staff on duty. Comments included, "Could do with some more staff" and "'It is safe, as far as they can, they try to, there are lots of people walk into the rooms."

● Prior to the inspection health care professionals had raised concerns about the staff levels at the service which they said were impacting on people's safety. On the day of the inspection the registered manager told us they had increased staff levels. They told us as a temporary measure they were supported with staff from one of the provider's other services and used agency staff to fill the gaps whilst they recruited for more permanent staff. However, we observed the deployment of staff around the service meant that people were still at risk.

● We observed one person who received one to one care from a dedicated member of staff was agitated

throughout the day. Their care plan stated they were more relaxed when supported by male staff. It also stated the person had been known to be more aggressive towards female staff, particularly during personal care. On the morning of the inspection, the one to one staff with the person was female and we noted from the person's behaviour records they were frequently supported by a female member of staff.

● During the inspection we had to intervene where behaviours from people meant this was putting other people at risk. For example, one person, who staff told us was frequently aggressive towards other people, was stood next to another person and became agitated with them. This was not observed by staff, so we took steps to redirect the person who was agitated to ensure the other person's safety. This was despite the person's care plan stating staff needed to be aware of the persons whereabouts at all times to keep everyone safe.

● Another person whose room was at the end of small corridor and staff were in the communal area was calling out to staff from their bedroom which was not being responded to by staff until we made them aware. Another person was restricted from entering the lounge as it was locked. There was no member of staff permanently based in the area where the person's bedroom was, and we observed the person frequently coming out of their room in the morning out of the eyesight of staff who were in the lounge.

● The registered manager advised us no dependency tool was used and the provider assessed the staff levels based on the numbers of people in the home. We were provided a copy of the staffing strategy that confirmed this. When people's needs had increased after being admitted, there was no evidence the provider re-assessed staffing needs. This placed service users at risk of not being supported by sufficient numbers of staff. This was despite their PIR stating, "The assessed needs of the residents predetermine the numbers and skills of the staff required at any one time."

As the provider had failed to ensure that staff were deployed effectively around the service which put people at risk this was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● After the inspection the registered manager told us, "I am going to be implementing a third (carer) looking at a floater (staff moving) between the two units. This will have a positive impact with the activity side of things. They can also assist anyone where needed."

●The provider operated effective and safe recruitment practices when employing new staff. This included requesting and receiving references and checks with the disclosure and barring service (DBS). DBS checks are carried out to confirm whether prospective new staff had a criminal record or were barred from working with people.

Using medicines safely

● On the day of the inspection we observed the nurse administering the morning medication. This took the nurse until lunch time to complete when lunch medicines needed to be provided to people. The delay in part was due to people often refusing the medicines and the nurse having to go back and offer the medicines again. We raised this with the registered manager who told us the morning medicine would not normally take this long and would take steps to address this.

● Despite this there were systems in place to ensure the safe administration of medicines. People's medicines were recorded in all the medicines administration records (MAR) with a dated picture of the person and details of allergies, and other appropriate information for example if the person had swallowing difficulties.

● There were medicines prescribed on 'as required' (PRN) basis and these had protocols for their use.

●The medicine audit was undertaken regularly, and all the nurses had been competency assessed to ensure that they had the skills required to administer medicines. The registered manager told us after the inspection they were also planning on doing some additional training with the nurses around medicine

administration.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

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.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Adapting service, design, decoration to meet people's needs; Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- The registered manager told us all of the people living at the service were living with dementia. The design of the environment was not set up to meet their needs. There was no clear signage to help orientate people to the communal areas or bathrooms, although people's care plans stated people required support to orientate themselves. People with dementia may need help with finding and recognising their bedroom. However, there were no dementia specific aids for people outside their rooms other than a name plate on the doors. We frequently observed one person walking into other people's rooms.
- People's bedrooms were not personalised, and the walls and bedding were both cream coloured with overall décor of the home in neutral colours. For people living with dementia the lack of distinguishable colouring could cause confusion. This was also fed back as a concern to the registered manager by visiting health and social care professionals prior to our visit.
- The provider had not considered making the best use possible of natural daylight for people. Most of the windows were blurred by using 'privacy screens' meaning people had no opportunity to see out of the windows. The provider told us these were used to prevent members of the public being able to see in the home. However, not all of the windows were facing areas where the public would be able to see in. One health care professional fed back they observed a person become distressed with the privacy screen in the lounge as they mistook their shadow cast by the privacy screen to be a person looking at them. The provider had not considered the use of one-way screens so people could look out without the public being able to see them.
- We found the call bells at the service to be loud in tone which could be alarming and distracting for people. The registered manager told us they also had concerns with the loudness of the call bells and wanted to make changes around this. The Social Care Institute for Excellence (SCIE) guidance states "Of all the senses, hearing is the one that has the most significant impact on people with dementia in terms of quality of life. Noise that is acceptable to care staff may be distressing and disorientating for a person with dementia." One of the call bell monitors was in the lounge seating area over one person's head. During the inspection the call bell went off multiple times. The room had a strong echo, so this was disruptive and could distress to people.
- There were people at the service that walked with purpose. There were no areas of stimulation or destinations areas for people to be involved in. One member of staff told us, "We could do with more dementia friendly environment, destination points, pictures and the décor." This was also a concern fed back to the service by a visiting healthcare professional who stated in the care notes the person they visited, "Likely felt imprisoned. He has only his room or corridor to walk about, he cannot leave which is frustrating him." Keeping the person who is living with dementia active and engaged can help to decrease their

distress and to reduce any anxiety and restlessness.
● The main living space had to be passed through to get to other corridors where people's bedrooms were. There were no separate seating areas or lounges for people to use. Therefore, people had no choice but to look at each other with minimal interaction from others. This was observed when a member of staff was trying to engage a person with sensory equipment to help alleviate their anxiety. The person kept getting distracted by people walking by interrupting what should have been a calming activity for them.
● People had been admitted to the service in quick succession before the registered manager and staff had time to fully assess their needs and behaviours. Between the 17 September 2021 and 21 October 2021 seven people had been admitted. Each person was known to have behaviours that challenged prior to them moving in. There was little opportunity for each their behaviour to be analysed before other people were admitted. This meant there was a potential that any new person being admitted might trigger behaviours in people already living at the service. This was also raised by visiting healthcare professionals to the registered manager. Despite this being raised people continued to be admitted.
● Staff fed back to us they also had this concern. One told us, "It's a positive for us to be admitting but being off for a few days and coming back to two new residents can be difficult. I have to read the pre-assessment and get to know the resident. It's too much." The providers. "Cornerstone Care Model" stated there needed to be an initial 28-day assessment. However, there was insufficient evidence this was taking place. During the inspection we asked for assurances from the provider that no further people would be admitted for now and they agreed to this.

As the provider had not ensured an assessment of the needs and preferences for care and treatment of people was undertaken appropriately and the environment had not been set up to ensure it met people's needs this is a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● The provider had failed to ensure suitably qualified and skilled staff were deployed to meet people's needs. There were people at the service that had a mental health diagnosis. However, when reviewing the training records provided the substantive staff had not received training around this. Although dementia training had been provided this was done via e-learning which staff told us could be improved with face to face training. Staff were also not trained to deliver essential end of life care medicines to people despite the provider admitted one person at end of life. The lack of training would also impact future people that were nearing the end of their lives.
● Staff had received training to positively support people in distress without the use of restraint. One member of staff told us, "You are not to grab them or block them, that keeps both you and resident safe." This was not always being followed by staff. We were made aware by health care professionals and through our observations where people were being restrained.
● The provider had used agency staff to support people at the service. Where they could they used the same agency staff for consistency of care. However, often agency staff were allocated to people on a one to one basis and had not always had the opportunity to understand their individual needs prior to that. One member of staff told us, "There aren't enough permanent staff, the agency staff don't have the same rapport with people." Another told us, "Having a lot of different faces can be upsetting (to people)."
● Staff told us they received supervisions with the registered manager. One told us, "They are useful because we get feedback. Having someone observe to provide some feedback to improve to get more knowledge." However, the supervisions staff received were not effective in identifying shortfalls that we identified on the day including the lack of modified texture diet training for the chef and it had not been observed by the registered and provider, until we and other health care professionals pointed this out, that people were being restrained by staff.

● Given the complex mental health needs of people, the provider had not ensured there were any mental health nurses working at the service. This was despite the providers care model stating, there would be a "Mix of general and mental health nurses."

As the provider had failed to ensure staff received appropriate training and supervision this was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

● Where decisions were being made for people there was not always evidence that their capacity had been assessed. For example, three people, who were living with advanced dementia, all had low beds restricting them from getting out of bed without staff assisting them with this. There was no assessment of the person's capacity to agree to this restriction to determine this was in the person's best interest or whether less restrictive measures had been considered.
● Decisions were at times being made for people where they had capacity to make their own decisions. For example, the registered manager told us there was one person at the service that had full capacity to make their own decisions. The person's care plan had conflicting information around this. It stated the person had full capacity including consenting to moving into the service. Yet, despite this a DoLS application had been submitted to the local authority stating that best interest decisions had been made for the person around all aspects of care.
● One person had a 'Do not attempt cardiopulmonary resuscitation' form in their care plan, however there was no evidence this had been discussed with the person or their representatives. Another person was receiving their medicine covertly (when medicines are administered in a disguised format without the knowledge or consent of the person receiving them). There was no evidence that a DoLS application had been submitted in relation to this restriction.
● There was a lack of understanding by staff of the principles of MCA. One of five main principles of MCA is that you assume a person has capacity unless as assessment has taken place to confirm otherwise. However, one member of staff told us, "Never assume they have capacity as it could be wrong." We were aware however that additional MCA training was taking place on the day of the inspection.

As the requirement of MCA and consent to care and treatment was not always followed this is a breach of regulation 11 (Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Supporting people to eat and drink enough to maintain a balanced diet
● Where people were assessed as needing a specific diet, this was not always provided in line with that

assessment. There were four people at the service who required a modified diet either soft and bitesize or minced and moist. However, the chef was providing all these people's meals in a puree form. This meant people who had some chewing ability did not have the opportunity to do this. The chef told us they had not received any training around the correct consistencies of food people needed to have.

● People on modified diets were not given the choice of what meals they wanted and instead the chef would make that choice for them. One member of staff told us, "I personally think people on soft food should have choices."

● Although meals were prepared fresh each day, we found the lunch had been prepared and plated up several hours before lunch time which included a rice dish. The chef told they then reheated each person's meal before it was served to people. However, care needed to be taken as the food health and safety guidance states when cooked rice is left at room temperature, spores can multiply and produce toxins which cause food poisoning which reheating will not get rid of.

● People were required to choose their meal the day before. We raised concerns people living with dementia may not recall what they had been offered the day before and visual choices on the day would benefit people more. The registered manager told us this was something they had also identified and agreed to take steps to address this.

● We saw when people requested food this was provided by staff and staff offered people drinks throughout the day. One relative told us, "(Family member) seems happy with food, what is served is good and nutritious."

● Where people were at risk of dehydration, this was closely monitored by staff. One member of staff told us, "We check our (handheld) devices, everyone is on a fluid watch. If it goes 'red' then they (people) need more fluid." Staff consulted an appropriate healthcare professional where a concern was identified.

We recommend the provider researches ways to support more effectively to enable choice in a way that considers their other care needs and abilities.

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

● Relatives told us their loved ones had access to healthcare professionals' support. One relative said the GP would often contact them with updates on their loved one's care.

● Staff worked with healthcare professionals to support people's care. We saw evidence of involvement from the GP, community psychiatric nurse, community matron and dietician.

● There were handovers before each staff changeover so staff could share important information about people's needs. One member of staff told us, "We work well as team 100%. We have quite a few different nurses and have a handover with them in the morning." We observed a night nurse providing information to the day nurse to ensure they were aware of any concerns.

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.

This is the first inspection for this newly registered service. This key question has been rated 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

- There were times during the inspection where staff were not as kind and caring as they could have been. On one occasion a person, who was in their room, had been having episodes of anxiety. When a member of staff approached the room to go in, they were heard to say out loud, "I hope he is in a good mood."
- Where people were on one to one with staff there was minimal interaction and at times the member of staff would sit in the chair without proactively engaging with the person for long periods of time. We observed two staff members, one sat next to person and one standing in front talking to each other and not engaging the person in their conversation. Staff often congregated in one place and talked rather to each other, even when standing next to a person
- Relatives however fed back that they felt staff were caring. Comments included, "Staff are very caring, it is great comfort" and "Staff couldn't be nicer."
- We saw occasions when staff interacted with people and this was done a kind and caring way. For example, one member of staff reassured a person as they were anxious about why someone bought him lunch believing they were due to go home. The member of staff was calm and rubbed their arm. The member of staff did not tell the person they were wrong about going home but calmed them and apologised to the person for bringing them their lunch. You could see this visibly calmed the person.

Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care

- People were not always supported with their independence. One health care professional told us they observed a person asking to go to the toilet. However, staff response to this was the person wore a continence pad and did not need to be taken to the toilet. This resulted in the person becoming incontinent. This was despite their care plan stating that person should be offered support to use the toilet and to always support and allow (person) to make decisions on their own and to respect those decisions.
- According to their care plan another person liked to be in his room and walk around, however the area they had to walk around in had been restricted to a small corridor as the door to the lounge had been shut and could not be accessed without a key code. This was only opened when we questioned with staff why the door had been closed. A member of staff told us this person liked his independence.
- When personal care was being provided this was done behind closed doors. If people removed their clothing in the communal areas staff supported them to their rooms to protect their dignity. Staff knocked on people's doors and waited for them to respond before they walked in.
- Family and friends were welcomed to the service whenever they wanted, and we saw this during the inspection. One relative told us, "I am very happy with the nurses and the care."

Requires Improvement

Is the service responsive?

Our findings

Our findings - Is the service responsive? = Requires Improvement

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

This is the first inspection for this newly registered service. This key question has been rated 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; 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; End of life care and support

- There was not always sufficient guidance in the care plans around the specific needs of people. This meant there was a risk that staff would not deliver the most appropriate care. For example, according to one care plan a person had chronic back pain. Their care plan did not contain clear guidance for staff about how to support the person with this other than to refer to the 'pain care plan' which was not included in the care plan for staff to review.
- Another person's care plan stated that staff were to support the person emotionally with no detail apart from to, "Encourage them to feel free to express emotions without being judged and to speak calmly and, slowly." Another person's care plan stated emotional support to be provided to them when distressed was going to the garden. Despite the person showing anxiety during the inspection, staff did not offer to take the person to the garden.
- There was conflicting information in some of the care plans which meant the person would not be appropriately supported. For example, in one care plan it stated the person may have some occasional difficulty in using the toilet. However, it then stated the person was incontinent and wore a continence aid. This meant staff might not support the person to use the toilet if they needed, particularly as the person became agitated when their continence aid was soiled.
- Daily care notes were task-focused and just recorded the care provided. The notes lacked person centred information such as how they felt throughout the day, what activities the person participated in and what conversation topics were spoken about. This information can help provide responsive and personalised care to a person.
- Care plans contained some information on the likes and interests that people had but this was not detailed. Staff did not always support the person to follow their interests. For example, according to their pre-admission assessment one person liked a particular type of music that helped them feel calm. However, the care plan did not detail what type of music. One health care professional told us they observed music being played for the person that they felt could have been triggering based on the person's previous employment.
- During the inspection there was a lack of meaningful activities and stimulation for people. One relative told us, "I take her in the garden, she hardly goes out." There were very little items provided by staff to interest and occupy people. People spent most of their time walking around followed by staff or sitting on chairs looking at others. There were no dedicated staff to provide activities. One member of staff told us,

"We don't have an activities coordinator, and this has an impact. We have our roles and try and activities. It would benefit people, they are bored."

● There was not sufficient information on what care people wanted and the end of their lives. Three of the care plans we reviewed stated the person needed an advanced care plan but then stated there was no immediate action required as person was well at present. However, one relative had fed back to the service about their loved one's care at the end of their life. They said, "I really appreciated your support in (family members) last few days. Just having someone on the same page has me helped enormously."

As care and treatment was not always provided that met people's individual and most current needs. This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

● Improvements needed to be made to assist people with communication. There were sections in people's care plans on how staff should communicate with people including to ensure face to face contact when speaking. One person also had flash cards to assist with this. However, there were no other aids used around the service that may assist people including picture menus or large clocks. The registered manager told us they were looking to address this and said, "We have ordered an interactive iPad for (person). They said of improving the communication aids, "That's another thing we can look at and fully embed that. Show plates (for meals) are being looked at to introduce."

Improving care quality in response to complaints or concerns

● Relatives told us they were able to approach the manager and staff team about any concerns they had. One relative said they had, "No complaint at all."

●At the point of our inspection the provider told us no formal complaints had been received. There was a detailed policy in place that provided information to people and their families on what they needed to do to make a complaint.

● Compliments had been received from relatives and visiting healthcare professionals. One relative fed back, "Many thanks for everything you are doing for (person)."

Requires Improvement

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.

This is the first inspection for this newly registered service. This key question has been rated Requires Improvement. This key question has been rated Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred 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; Continuous learning and improving care

- There was a lack of robust oversight from the provider to ensure the quality and safety of care being provided to people. The provider's quality assurance manager told us they undertook quarterly audits on infection control, medication, oral hygiene and care equipment. They told us an action plan was generated as a result of these audits and presented at the provider level clinical governance meetings. However, when we reviewed the action plan the audits had not identified many of the shortfalls we identified at the inspection including the poor management of risks associated with people's behaviours, the lack of meaningful activities for people or poor layout of the environment to effectively address people's individual needs.
- Opportunities to make improvements to people's care were missed as there was no robust analysis of accidents, incidents and behavioural incidents undertaken by the provider. The provider told us they had oversight of all this. However, when we reviewed the analysis, there was no meaningful information to determine where improvements could be made. For example, according to their falls analysis there had been 22 falls between 10 June 2021 and 21 October 2021 of which nine were unwitnessed. There was no information on the times of day these occurred or what preventative measures had been taken to prevent further occurrences.
- After the inspection the provider told us of the analysis of all incidents including behaviours, "The Cornerstone Clinical Governance Group review all incidents on a monthly basis and support the specific service in identifying trends and implementing actions to address." The PIR stated, "We have an internal Quality and Compliance team who use RADAR analytical tools to highlight trends and potential areas of risk and good practice which can be shared." However, we found this was not taking place.
- The provider had not considered that admitting people to the service as quickly as they were had an impact on the safety of the care being provided. They told us at the inspection that they had ensured people were admitted safely. However, we found this was not always the case and people were being put at risk by staff not having the opportunity to learn about the needs of people before another person was admitted.

As the provider had failed to undertake robust quality checks this is a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager had been newly recruited to the service and was taking steps to make

improvements. We could see they had updated their action plan after the inspection to include some of the areas of concern we identified, including improving activities. The provider told us they planned to undertake an audit of the home every six months; however, it had not yet been open long enough.

● Relatives told us they were happy with management of the service. One told us management said to them, "Anything we can do let us know. They are very approachable and responsive."

● Staff we spoke with were complimentary of the registered manager with comments including, "I think (manager) is good, shows great leadership, very approachable" and "(Manager) and (Provider) are absolutely great. I feel 100% supported."

● Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events which happen in the service. After the inspection we identified an incident of safeguarding that had not been notified to CQC. We noted in the behaviour records one person had been observed hitting another person, this had not been reported to the CQC.

As notifiable incidents were not always been sent in to the CQC this is a breach of regulation 18 of the (Registration) Regulations 2009.

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

●Where incidents and accidents had occurred, we noted from the records families were contacted.

●The registered manager and staff worked with external organisations which regularly supported the service. This included staff from the local health centre, the Clinical Commission Group and the local authority. One health care professional fed back to the service in September 2021, "During my visits I noted the patient was presenting much more relaxed especially when moving in communal areas and engaging with staff and other residents."

● After the inspection a health care professional fed back to us the registered manager was attending the Care Home Forum and was taking steps to link in with local homes to review their dementia environment. They told us, "I do feel (registered manager) is trying to make moves in the right direction and have also found her to be transparent."

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

● There were no formal meetings at the service for people or their families however relatives commented they had felt involved and were updated about any changes to the service.

● The provider was in the process of reviewing surveys to relatives to gain their views. At the time of the inspection the survey was still open, so no information was available for us to review.

● A staff survey had taken place which had been analysed by the provider. Comments provided on the survey from staff included, "I have only been employed since June this year but I already feel valued within my role" and "I find it a lovely place to work, I am always made to feel welcome when I do a shift." This was also echoed by a member of staff who told us, "I feel valued, for me it's the little things like 'thank you'. (Registered manager) says 'thank you, you are doing a great job.'"

● There were daily meetings with staff to talk through any changes in people's needs. The registered manager told us they were introducing more formal monthly meetings. They said, "We have a monthly feedback form that I share with all the staff. I need to capture the day and night staff."

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 18 Registration Regulations 2009 Notifications of other incidents The provider had not ensured that notifiable incidents were not always been sent in to the CQC.

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 The provider had failed to ensure the requirement of MCA and consent to care and treatment was always followed.

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 The provider had failed to ensure that staff were deployed effectively around the service which put people at risk and staff were not appropriately trained and supervised in their role.

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 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured an assessment of the needs and preferences for care and treatment of people was undertaken appropriately and the environment had not been set up to ensure it met people's needs. Care and treatment was not always provided that met people's individual and most current needs.

The enforcement action we took:

We issued a warning notice in relation to this breach.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to manage risks associated with people's care in a safe way.

The enforcement action we took:

We issued a warning notice in relation to this breach.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to report safeguarding incidents where appropriate to safeguard people from the risk of abuse and improper treatment and people were being unlawfully restrained.

The enforcement action we took:

We issued a warning notice in relation to this breach.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that quality checks

Treatment of disease, disorder or injury

and leadership was always robust.

The enforcement action we took:

We issued a warning notice in relation to this breach.