Fairfield View Care Limited

# Fairfield View

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

About the service
Fairfield View is a residential care home providing personal care for up to 54 people. The service mainly provides support to older adults and people living with dementia. At the time of our inspection there were 50 people using the service.

Care is provided across two units, with 'The Elms' providing specialist dementia support. People have their own bedrooms, some of which were ensuite. Communal spaces including bathrooms, living spaces and a secure garden were available.

People's experience of using this service and what we found
Systems for oversight were not effective at all levels of management. The provider had not ensured sufficient oversight of the home to identify areas of concerns or ensure the registered manager had the systems, resources and support to maintain oversight of the quality of care. It was not clear how people were engaged in driving improvement across the service.

Systems to identify and mitigate risk were not effective. Medicines were not always being safely managed and administered. The service was following suitable recruitment processes but further work was needed to ensure a robust recording system was in place. Further work was needed to ensure good infection control processes were being followed. Lessons were not always clearly learnt when incidents occurred, and sufficient and timely action was not always taken to address shortfalls when identified.

People's assessments were not always accurate or complete and incorporated into their care plans. Staff had not always completed the necessary training, and feedback and evidence of staff support, such as staff supervisions was varied and inconsistent. The environment and equipment needed updating or replacing to ensure it met the needs of people. Further work was required to ensure people had their nutritional needs met but people generally enjoyed the food provided.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service were in place to support good practice.

People had mixed views on how they were cared for. We observed staff did not always promote choice and independence and dignity was not always considered. People were not always clear how they had been involved in decision making.

People's care was not always personalised. Further work was required to ensure staff met people's communication needs, reduced the risk of people's experiencing social isolation through personalised activities and captured people's views and end of life preferences.

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 good (published 10 December 2018). At our last inspection we recommended that the service consider best practice guidance regarding making improvements to the home to assist people who lived with dementia and review systems for maintaining accurate records of staff training. At this inspection we found limited progress had been made in these areas.

Why we inspected
This inspection was prompted by a review of the information we held about this service. A decision was made to seek further assurance through an inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

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

The registered manager advised they would take appropriate action to address the concerns identified at inspection and wanted to ensure that people received good quality care.

Enforcement and Recommendations
We have identified breaches in relation to the management of environmental and individual risk; safe handling of medicines; provision of personalised care; ensuring people are cared for in a dignified way; ensuring that staff have the necessary skills and training to meet people's needs; and there is sufficient management oversight to identify shortfalls and improve the service.

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

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

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

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

## The five questions we ask about services and what we found

We always ask the following five questions of services.

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

# Fairfield View

**Detailed findings**

## Background to this inspection

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

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

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

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

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

Notice of inspection
This inspection was unannounced on the first day.

What we did before the inspection

We used information gathered as part of monitoring activity that took place on 20 July 2022 to help plan the inspection and inform our judgements. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We sought feedback from the local authority, professionals who work with the service and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection
We reviewed staffing levels and walked around the building to ensure it was clean and a safe place for people to live. We observed how staff supported people and provided care.

We spoke with ten people who use the service, three relatives and ten members of staff including the registered manager, unit manager, care workers, and auxiliary staff including kitchen staff and activity worker.

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

We spoke with the nominated individual following the site visit to find out more about the provider oversight in place. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

Inadequate

# Is the service safe?

## Our findings

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

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

Assessing risk, safety monitoring and management

- Systems to assess, monitor and manage risk were not always in place or sufficiently robust.
- External checks of equipment had been completed. External risk assessments had been completed in areas such as fire and legionella risk. However, the service was unable to demonstrate the actions they had taken in response to any improvements or recommendations made.
- Regular maintenance checks of systems such as water temperature and fire equipment were not happening consistently. This meant shortfalls were not being readily identified.
- Environmental risks were not effectively identified and remedied. People had access to unsafe areas such the sluice and cleaning cupboard. Areas of the home were in need of redecorating and we found items of broken furniture which could cause a person injury.
- Risk assessments were completed regarding individual need but not were not always accurate. For example, accurate body mass index (BMI) records were not maintained to ensure accuracy of risk assessments, and there was no consistency in the completion of risk assessments.
- An individual's known risks did not always lead to their effective management. People's needs and risks were not always readily identifiable, and information about how to reduce risk was not consistent or accurately recorded in care plans. For example, the impact of being visually impaired was not always considered as part of how a person was supported physically and emotionally by staff.
- Staff had not identified and accurately recorded areas of potential risk to ensure sufficient oversight. For example, records around wound care were not accurately maintained and there was a lack of guidance for staff on how to safely manage a person's skin integrity. Falls had not led to timely reviews of care plans to ensure risks were mitigated. Incidents such as verbal aggression were not always being recorded. This made it difficult for staff to understand triggers to people's distress, identify potential vulnerabilities and mitigate these.

Risks were not always being assessed and mitigated. This placed people at risk of harm. This was a breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager and management team were responsive to our feedback. The maintenance team took immediate action to remedy any shortfalls we found in routines checks on the environment. The registered manager advised the provider had identified the need for improvement with regard to systems for assessing and recording individual care needs and were in the process of seeking an appropriate solution to the care planning system.

Using medicines safely

- People did not always get the medicines they needed; records were not accurately maintained.

● Some people had missed medicines due to them not arriving from the pharmacist in time. Staff took action to chase up any missing medicines, but the impact of missed medicines to people's wellbeing was not clearly considered or monitored.
● Medicines were not stored safely. Temperature checks of storage areas were ineffective as incorrect temperatures were not recognised and escalated to ensure medicines where stored in line with manufacturer instructions.
● Staff were not consistently checking that medication administration records (MARs) were being maintained accurately. We found some medicines which had not arrived from the pharmacy had been signed as given; some medicines had been signed twice as there were duplicate records; and where a full dose of medicine had not been received there was no accurate records of what had been administered by staff.
● Systems to ensure time sensitive medicines were given appropriately, such as early morning medicines or medicines which requires a specific time frame between doses, were not suitably robust. We observed the morning medication round was still being administered at lunchtime.
● Systems for ensuring people received their creams as prescribed were not effective. Care plans did not provide consistent guidance for staff. MARs and daily notes did not reflect creams were being used consistently and did not always correlate with the creams found in people's bedrooms.

People's medicines were not always being properly and safely managed. This placed people at risk of harm. This was a breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager and management team took action to address the shortfalls we found during the inspection. This included escalating the concerns over storage temperature for medicines, and reassessing staff competency to administer medicines.

● Protocols to guide staff on how to administer medicines that people received occasionally, such as medicines for pain, were in place and detailed.

Staffing and recruitment
● Suitable recruitment processes were being followed. Checks with previous employers and disclosure and barring service (DBS) were made. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. However, further work was needed to ensure robust and auditable records were in place.
● The home was struggling to recruit the staff required to meet people's needs. This had been identified as an issue by the provider and action was being taken to address this. People told us the home was sometimes short staffed, and this impacted on response times and how people were supported with their care needs. We observed staff were busy and task focused.
● The home used agency staff to cover shortfalls and requested consistent agency workers; but this was not always provided by the agency. Processes to mitigate the risk of high agency staff levels were not robust as people's risk and care needs were not always readily identifiable within care plans, in handover records or in people's rooms. This meant people may be cared for by staff who were not aware of their individual care and support needs.

Systems to ensure that staff providing care have the appropriate qualifications, competencies, skills and experience to do so safely had not been implemented effectively. This placed people at risk of harm. This was a breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● The home was mainly clean but there were some areas, and furnishings were in need of replacement to ensure they could be effectively cleaned. There had been a recent external audit which noted the home was overall compliant, but the areas of shortfall identified in this audit had not been actioned by the time we inspected the service. For example, additional wheelchairs had been ordered, but not yet arrived. This meant people were using a shared wheelchair when they did not have their own.

● Staff were using personal protective equipment (PPE). We found some areas of the home where PPE was less accessible due to potential risk and discussed this further with the registered manager. Staff did not always ensure their masks were well fitted and we noted some shortfalls regarding staff donning and doffing of PPE which we fed back to the registered manager. The service completed checks of hand hygiene.

● Good infection prevention and control measures were not always being followed by staff. For example, with regard to dress code. We observed the registered manager speak to staff where shortfalls had been identified, but a consistent approach to checking and addressing this was not in place.

● The provider had an infection prevention and control policy. However, it was not evident that staff had completed all the necessary relevant training in this area.

The home was not following the most up to date guidance for supporting people to visit their loved ones at the home. At the time of the inspection we were told visits were pre-book only, the visits were time limited and took place in a secure visiting pod. The registered manager explained they had a recent outbreak of COVID-19 and consequently wanted to reduce risk to people. The registered manager was advised of the need to follow guidance.

Systems and processes to safeguard people from the risk of abuse

● Systems were in place to keep people protect people from the risk of abuse; most people told us they felt safe at the service. People told us, "I feel safe as nothing has ever gone wrong and they are all lovely to be with." and, "There is no trouble here." However, some people raised concerns about some staff behaviours, and the use of agency staff impacted on how well staff knew people and the processes in the home.

● There were procedures and processes in place regarding safeguarding and the registered manager worked with the local service to investigate safeguarding concerns. There were some shortfalls in staff training and we could not be certain that all staff understood how to recognise abuse and when to escalate issues which may be safeguarding concerns.

Learning lessons when things go wrong

● It was not clear that lessons were learnt effectively.

● The provider had systems in place for updating managers and supporting lessons to be learnt across the care homes. However, this information did not always lead to actions being taken in the service.

● Incidents were not always robustly recorded to enable analysis and lessons to be learnt about how incidents occurred. Where incidents had occurred, this had not always led to quick action to prevent reoccurrence. For example, following incidents such as a fall or pressure injury people's care plans had not always been updated to incorporate these incidents and any new mitigation. The provider was in the process of identifying alternative systems for care planning, recording and oversight as they recognised these were not effective for oversight of people's needs and the quality of the service.

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

Staff support: induction, training, skills and experience

At our last inspection we made a recommendation that the registered manager review systems in place to ensure accurate records of staff training were maintained. The provider had not made the required improvements.

- Systems to ensure staff were suitable trained, skilled and supported in their roles were not sufficiently robust.
- The registered manager did not have access to current training records, due to administration challenges. This was updated and provided to CQC; however, there were numerous gaps in training. The registered manager explained that a number of face to face training sessions had stopped during the COVID-19 pandemic. Staff had recently accessed some training offered by external organisations, such as pressure care and mental capacity and this was ongoing. We were told the provider was in the process of sourcing suitable training for all their services.
- The registered manager and team had completed some competency assessments with staff, such as medicine administration and hand washing. However, it was not clear that everyone's competency had been assessed in the relevant areas. For example, there was no evidence of manual handling practical assessments. A member of staff had recently been trained in this area and would be undertaking this work with staff.
- Staff generally told us they felt supported but supervisions were not completed consistently. Some staff had not had supervision or had long gaps in between, whilst others had regular supervision. Further work was required to ensure staff were consistently supported especially night staff due to a number of senior care staff vacancies. This had created difficulties in ensuring shifts were effectively led and staff appropriately supported, directed and supervised.
- Our observations of staff practice during the inspection indicated training was not sufficient and further support and education with staff was needed in a variety of areas. For example, we observed occasions where people were not transported safely around the home and where people were not supported with consideration to their dignity.

Systems to ensure staff had appropriate support, training, professional development, supervision and appraisals to carry out their duties were not being effectively used. This placed people at risk of harm. This was a breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

At our last inspection we made a recommendation that the service review the environment and make adaptions to the premises in line with best practice guidance when supporting people who lived with dementia. The provider had not made improvements.

● The environment was dated and needed attention, with furniture needing replacing.
● There was a lack of sufficient oversight of the environment and equipment to ensure it was fit for purpose.
● People's bedrooms were often bare and lacked personalisation. We were told this had been impacted by the COVID-19 pandemic which had meant families had not been inside the home. However, it was not clear that following the changes in guidance families had been encouraged to visit people in their rooms.
● The environment was not always suitable for people living with dementia. For example, one person living with dementia had a care plan which noted they did not like noisy environments and would become distressed causing them to lash out both physically and verbally. However, we saw they were in a noisy environment throughout the day and there was a lack of quiet communal spaces on this unit.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Records did not demonstrate that people's needs were being assessed accurately.
● Care plans were often inconsistent in the information provided and guidance given on how staff should meet people's needs.
● It was not clear that current assessments, needs and risks were being accurately maintained to ensure that these were reflected in relevant care plans. For example, where a risk such as weight loss was identified, it was not always evident that this was monitored, and relevant action taken such as weekly weight or fortified meals and additional snacks.

Supporting people to eat and drink enough to maintain a balanced diet
● People were not always supported to eat and drink in line with their assessed needs.
● People generally told us the food was good. One person commented that, "The meals here are very good." However, we were also told, "There are no menus and I never know what I'm getting to eat."
● People's care plans did not always clearly and accurately reflect people's dietary needs. Staff did not all know people's specific dietary needs. Care plans did not always reflect guidance around eating given by the speech and language therapy team or dietician service. For example, one person had been prescribed a modified diet but their care records had mixed information about the consistency of this and we observed they received a more modified diet than they needed. The kitchen staff had a copy of assessments for people on a modified diet, but some people's information was missing.
● Choice was not always promoted; drink options and snacks lacked variety. People were not consistently asked what they wanted to eat and drink and this was feedback to the registered manager. Night staff did not have access to kitchen stock in order to provide people with a variety of supper options. They were reliant on kitchen staff leaving enough and a variety of supper and snack options for use.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People were supported to access primary health care service such as doctors and district nurses, however some healthcare provisions such as dental care were difficult for the home to access.
● We noted a number of people had significant oral health care needs, including the need for dentures to be replaced. The registered manager advised this was an ongoing challenge for them to access dental care. We advised the service to make safeguarding referral for those most at risk and we escalated this concern with the local integrated care board.

● Staff had identified people who were developing pressure injuries or skin related damage and had made the relevant referrals. However, records did not always demonstrate when injuries had been identified, body maps were not being used effectively and advice given by relevant health care professionals, such as the application of creams or pressure relief was not incorporated into people's care plans. Daily records did not demonstrate how pressure relief was being consistently given although there was no evidence that people had come to significant harm as a result.

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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● Records did not demonstrate the service was working in line with the MCA.
● Feedback from people, and our observations during the inspection were mixed. We observed some good examples where choice was promoted, but other examples were people were restricted without consideration to least restrictive options.
● Decision specific capacity assessments and best interest decisions were not evident in records. It was not clear that appropriate people had been involved where people lacked capacity to make decisions themselves.

Requires Improvement

# Is the service caring?

## Our findings

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

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

Respecting and promoting people's privacy, dignity and independence
- People's privacy, dignity and independence was not always respected by staff.
- Staff did not always recognise the need for early intervention in order to protect people's dignity. For example, we observed one person would put themselves on the floor and crawl in communal areas. Staff saw this behaviour as normal and did not always intervene prior to the person reaching the floor.
- People were not always able to go to their bedroom and have privacy if they wanted to. We observed some people asking to return to their bedroom, but due to their needs and risk staff did not support this request. There was limited evidence to show consideration had been given as to how staff could safely support this.
- People were not always supported to maintain relationships with loved ones due to the visiting restrictions imposed at the time of our inspection.
- We observed examples of personal care being given to people in communal spaces. This was not noted or challenged by other staff, although we noted that the registered manager would address such shortfalls when made aware.
- We observed people left alone in their rooms for long periods of time without access to a call bell. some people did not look well kempt and had dirty fingernails. Care records did not show that people were having have regular baths, showers or daily oral care.

Systems were not in place to ensure that people were treated with dignity and respect. This placed people at risk of harm. This was a breach of regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring people are well treated and supported; respecting equality and diversity
- People's views of how staff cared for them was mixed. We received some positive comments such as, "I think the staff are pleasant, caring and helpful people." However, other feedback was more mixed and included comments such as, "Sometimes they are caring but sometimes they are not" and, "I think that staff are a bit on and off."
- We observed staff were generally kind and caring when supporting people and permanent staff understood people's needs and likes. However, equality and diversity were not always promoted as people were not consistently receiving personalised care. Care records did not demonstrate a holistic approach to people's specific needs, such as people from a different cultural background. Staff did not always ensure that the equipment people needed, such as glasses were in place.

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

● People were not consistently supported to make choice and be involved in decision making.

● We observed people were not consistently supported to make decisions for themselves around their daily lives. This was more apparent where people lacked or had fluctuating capacity. Feedback from people was mixed with some people commenting that staff respected choices and other not having this experience. One person commented, "The staff don't listen to what I say and at my age I don't want to be told what to do all the time."

● Records did not demonstrate people were supported in decision making and sharing their view in relation to care plans. People and families were not able to tell us how they had been involved in making decision about their care. The registered manager told us a resident of the day scheme was used to collects peoples' views, but no formal records were being maintained at the time of the inspection.

Requires Improvement

# Is the service responsive?

## Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

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

- Care plans were not consistently personalised to meet people's needs and preferences.
- Care records did not always contain enough detail about people's specific needs, how staff should support these needs and people's preferences. The approach to care plans across the service was not consistent.
- The service used a 'this is me' document which provided an overview of people's life and was available for staff to review in people's bedrooms. This did not clearly link in with people's care plans, and staff knowledge about people was not clearly captured in care plans or daily records. Handover records were not being utilised to help new and agency staff understand people's needs, choices and preferences.
- Records did not demonstrate that people were having care in line with needs, such as dietary needs, pressure relief and personal care. There were restrictions on people visiting in the home, and choice and decision making was not always promoted.
- People had meals in the lounges on small tables as there was not sufficient space in dining areas for people to eat there should they prefer to. Not all small tables in the lounges were sufficiently high to ensure people ate safely in a way to reduce choking risk and improve dietary intake and digestion. People often had to wait before being offered their breakfast. The premises was not always suitable to meet people's preferences.

People were not consistency receiving personalised care that was appropriate, met their assessed needs and reflected their preferences. This placed people at risk of harm. This was a breach of regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

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

- People did not consistently have communication care plans that contained detail to guide staff.
- The quality of care plans varied. Some records referred to equipment people needed, such as hearing aids or glasses, but others did not explicitly recognise any impairment people might have and how these could be met.

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

● An activity worker was in post. They worked hard to offer a range of activities, themed events and outings across the two units. They were keen to develop further community links and resources to use with people. One person commented, "I think that the armchair exercises are good, especially the one with the balls."

● Further work was needed to enhance the range and availability of activities for people, especially individualised activities for those who did not wish to access groups and those cared for in their rooms. One person being cared for in their bedroom told us, "I don't have any activities up here."

● The registered manager said two activity workers were usually in post and they were recruiting additional resources for activities. We will review the impact of this for people at our next inspection.

Improving care quality in response to complaints or concerns

● The registered manager understood the principles of responding to complaints and concerns.

● The majority of people felt able to raise concerns with staff or the registered manager. However, this was not the case for everyone, and based on the mixed feedback we received from people further work should be undertaken to ensure people feel able and confident to raise concerns.

● The service had not received any recent complaints from people or families, but had received compliments. We discussed how to capture low level feedback and concerns from people and families with the registered manager to enable oversight of any themes or trends which could be used to drive improvements within the service.

End of life care and support

● People did not always have detailed end of life care plans in place.

● At the time of the inspection nobody was receiving this type of support. However, it was not evident whether people had refused to discuss this aspect of care or this had not been discussed.

● Evidence from the training matrix suggested only a small number of staff had completed any training in this area recently.

Inadequate

# Is the service well-led?

## Our findings

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Continuous learning and improving care

- There was insufficient oversight of the service to ensure people received good quality, safe care.
- There was limited evidence of provider oversight. The nominated individual told us that the provider had struggled to recruit appropriate people in this role and accurate records and oversight had not been maintained by previous individuals in senior management roles.
- The registered manager completed some audits of the quality of service. However, these were not being consistently completed and were not comprehensive in considering all aspect of care and the quality of the service. The audits done had not effectively identified and escalated the shortfalls noted during this inspection, such as the arrangements for medicine storage although it was evident that this had been an ongoing issue at the service.
- At the last inspection we made a recommendation about reviewing the premises in line with good practice guidance for people living with dementia and ensuring an accurate record of staff training was being maintained. The necessary improvements had not been made at this inspection.

Systems to assess, monitor and improve the quality and safety of the service were either not in place or not being used effectively. This placed people at risk of harm. This was a breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the provider told us about a variety of tools and systems which would be implemented to support the registered manager to maintain oversight of the service.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- People were not always achieving good outcomes as care that was person centred, inclusive and empowering was not always being delivered.
- Feedback about the service was mixed. Some people spoke very highly of the service, but others shared concerns. One person commented, "Staff know me quite well and I would recommend the home." However, another told us, "I used to like it when I came at first, but it has changed a lot." A family member commented, "I don't know anything about the place apart from what I see when using the pod (visiting area)."

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 the duty of candour. Records, however, did not support the registered manager to be open and honest with people if something went wrong as information was not always being captured accurately.

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

● The registered manager would address poor practice when identified. However, there were no formal structures to record these in order to escalate any specific concerns or look at themes and trends.

● Further work was necessary to ensure effective oversight at all management levels. Both the registered manager and unit managers needed further support to implement improvements, access relevant training and ensure the resources necessary to maintain oversight of quality, risk and regulatory requirements were in place.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● Systems for involving people and families were not being used effectively.

● The home completed resident and family meetings prior to the COVID-19 pandemic but this had not been replaced with other processes or reintroduced following the relaxation of restrictions.

● Surveys had been completed with people but had not elicited information which could be used the make improvements in the service. People were not able to tell us how they had been involved in feedback. One person said, "There has not been any opportunities to comment or feedback our view apart from our brief chats with the registered manager."

● Staff generally told us they felt the manager was approachable, although not all staff felt listened to. One staff member told us, "The manager is always there for us to help us. I've never raised any concern with them, but we do have chats."

● The service worked with external professionals and had previously had good relationships within the community. This needed to be rebuilt following the COVID-19 pandemic.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>People were not consistency receiving personalised care that was appropriate, met their assessed needs and reflected their preferences. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br><br>Systems were not in place to ensure that people were treated with dignity and respect. This placed people at risk of harm. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Systems to ensure staff had appropriate support, training, professional development, supervision and appraisals to carry out their duties were not being effectively used. |

This section is primarily information for the provider

# Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>People's needs, and risks were not always being assessed and risks mitigated.<br><br>People's medicines were not always being properly and safely managed.<br><br>Systems to ensure that staff providing care have the appropriate qualifications, competencies, skills and experience to do so safely had not been implemented effectively. |

**The enforcement action we took:**

Warning notice

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Systems for oversight to checks the safety and quality of the service were not being used effetively. |

**The enforcement action we took:**

Warning notice