Ladymead Care Home Limited

Ladymead Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Ladymead Care Home is a care home registered to provide nursing and residential care for up to 27 people over 65. People living at the service had varying health conditions, including dementia, diabetes, Parkinson's disease, heart and respiratory failure and other age-related frailties. There were 19 people living at the service at the time of our inspection.

People's experience of using this service and what we found
People were not always protected from risk of abuse; people had been deprived or their liberty without having their mental capacity robustly assessed.

People's associated health risks were not appropriately assessed, care planning was not person centred and did not always consider people's dignity and health needs. The service had a high reliance on agency staff. Without clear guidance from care records, agency staff were unable to provide a continuity of care to people. People did not always receive their medicines in a timely way and in accordance to best practice.

People were not always protected from COVID-19 infection prevention and control measures. Visiting professionals and agency care staff members were not always asked to prove their vaccination status or requested proof of a negative lateral flow device test result.

People, their relatives and staff commented on the high turnover of management at the service. One relative told us, "There has been too many managers." The service had not learned lessons from previous inspections. The provider had submitted action plans to CQC which were not robust and had not been followed through. The provider did not always record and learn from complaints about the service. One relative told us, "The owners could do a lot more."

People were not always 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.

We received mixed feedback about the food provided at the service. People were able to choose what they wished to eat. One relative told us, "The food is ok, typical care home food, it's all bought in, the new chef is going to be cooking." And, "Since my relative has been at Ladymead, they have put on a stone of weight, they are much better."

People had access to healthcare services and staff supported them to attend appointments. Professional guidance had not always been recorded in people's care documentation.

People, their relatives and staff gave mixed feedback about the leadership and management at the service. Comments included, "I'm comfortable to feedback to the manager, since the old manager left, I feel I have

more opportunity." And, "The higher management team come and stick a plaster on the problems."

Staff were observed to be kind and considerate to people. Staff told us they liked working with the people living at the service. Comments included, "Sometimes they make you feel happier and perk you up." And, "The best things about working is here is the residents, the people, the staff, my heart is tied to this place. I get fulfilment and enjoyment. I can walk away feeling like I have achieved something."

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 23 April 2021). There were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

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

We received concerns in relation to lack of activities for people and concerns regarding falls, nutrition and staffing. This inspection was also carried out to follow up on action we told the provider to take at the last inspection.

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

We have found evidence that the provider needs to make improvement. 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.

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

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

We have identified breaches in relation to safeguarding people from risk of abuse, assessing risks to people, infection prevention and control, medicines management, implementation of the Mental Capacity Act 2005, staff training and supervision, dignity and respect, good governance and notifying CQC of events within the service at this inspection.

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

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.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Ladymead Care Home

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was undertaken by two inspectors, a medicines inspector 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
Ladymead Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. The registered manager 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. We sought feedback from Healthwatch, which is an independent consumer champion that gathers and represents the views of the public about health and

social care services in England. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with 11 people who used the service and four relatives about their experience of the care provided. We spoke with seven members of staff including the operations manager, manager, deputy manager, registered nurses, care workers, housekeeping staff and the chef.

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

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with three health care professionals who regularly visit the service, two staff members and two relatives of people who use the service. We sought some urgent assurances from the provider about management arrangements and individual risk assessments for people.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse
At our last inspection the provider's processes did not ensure the right level of scrutiny and oversight to ensure people were protected from abuse and improper treatment. This was a breach of regulation 13 (Safeguarding people from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13

● At the last inspection systems and processes were not in place to protect people from the risk of abuse. Incident records and daily notes showed there had been a failure to consider some injuries in line with safeguarding guidance.
● At this inspection, improvement had been made; accidents and incidents had been considered in line with safeguarding guidance. Staff received refresher training and followed local safeguarding policy guidance. However, further concerns were identified in safeguarding people from restrictions to their liberty.
● Processes in place to ensure people were not deprived of their liberty for the purpose of receiving care without lawful consent were not consistently applied. For example, a restrictive practice was in place for one person regarding leaving the premises alone. Staff received written guidance to lock the doors and to monitor the person in communal spaces. It is acknowledged this action was to keep the person safe, however, this was implemented without the provider seeing seeking lawful consent regarding this decision. This meant the person was unlawfully detained by the service without regards to their mental capacity to make this decision.
● After the inspection CQC raised five concerns to the local authority for consideration in line with their safeguarding adults guidance. These were about restrictive practices relating to depriving people of their liberty without lawful processes being followed.

The provider's processes did not ensure the right level of scrutiny and oversight to ensure people were protected from restrictions. This was a continued breach of regulation 13 (Safeguarding people from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The management demonstrated their understanding of reporting safeguarding issues to external bodies where appropriate. Records showed this had been completed appropriately.
● Staff received training and were aware of their safeguarding responsibilities. Staff understood the different types of abuse and how to recognise these. Staff were aware of who to report to externally should this be required. One staff member told us, "I would go to management, I could go to the CQC or local authority and

can raise a safeguarding."
● The service's safeguarding policy was up to date and reflected the local authority's guidance.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

● At the last inspection, risks to people were not identified and managed. Where care plans identified a known risk, records were not always sufficient to ensure safe care. At this inspection there was continued evidence of risks to people not being managed safely.
● Prior to this inspection, we received information of concern regarding the management of falls at the home. Risks from equipment, such as bedrails had not been assessed for individual's safe use. Risks such as entrapment and restricting movement had not been assessed. For example, one person had fallen whilst attempting to climb over their bed rail. Their continued use of bedrails had not been reassessed and other options had not been considered to mitigate the risks of reoccurrence and injury.
● People had not been individually risk assessed when they experienced swallowing difficulties. Professional advice had been given by the speech and language therapists (SaLT); SaLT advice had not been clearly transferred over to the care planning system. Where people required a modified diet, there were inconstancies in the advice available to staff. For example, one person required a diet prepared to the International Dysphagia Diet Standardisation Initiative (IDDSI) level six 'soft and bite' sized consistency. This information was not reflected within the person's nutritional care plan and a choking risk assessment had not been completed. One persons' care record stated they required a 'pureed diet', there was no SaLT assessment record to support this. Permanent staff knew who required a modified diet, as the service relied on agency staff members people could not be assured of receiving the correct support to reduce the risk of choking and significant harm. Following the inspection provider provided some immediate assurances around people's choking risks being risk assessed and highlighted at staff handover.
● Guidance for staff for people living with diabetes was confusing. There were no instructions for staff on how to recognise the signs of when people's blood sugars were unstable such as lethargy or an increased thirst. Where people may experience high or low blood sugar levels, information was not available for staff of what actions to take. For example, to give the person a high sugar content snack or drink, to administer insulin or to call for emergency professional advice.
● People had not been accurately risk assessed for malnutrition. People's weights were not being effectively and consistently monitored. Staff used incorrect measurement units when calculating people's body mass indexes (BMI), the system required the units to be entered in centimetres, but staff had entered the figures in feet.
● BMIs are used to calculate the malnutrition universal screening tool (MUST) score. MUST is a recognised tool which identifies people who are at risk of malnutrition. MUST score outcomes guide staff on actions to take when people are at risk of malnutrition, for example, referrals to dieticians or to monitor food intake. A person who had an incorrectly calculated MUST score had lost significant weight and had not been referred to a dietician. This left them at risk of further malnutrition and associated complications such as damage to their skin integrity.
● Risk of pressure damage to people's skin integrity was not always assessed or managed effectively. Staff used the Waterlow assessment tool; this tool helps identify where people are at risk of pressure damage to

their skin. Accurate BMIs and MUST scores are required to complete the Waterlow. Due to BMIs being incorrectly calculated, we could not be assured the Waterlow tool gave a correct score. The Waterlow outcome would guide staff on actions to take to minimise pressure damage.

● Waterlow assessments were not carried out consistently and in line with the provider's policy which stated assessments should be undertaken monthly. We saw one person's Waterlow assessment tool had not been completed for five months. Without monthly assessments, people's risks may not be identified, and appropriate interventions may not be sought which may lead to people sustaining pressure damage.

● Some people required airflow mattresses, which help reduce the risk of people developing pressure sores. Information was not contained in the care records to guide staff on the correct airflow settings to ensure correct pressure area support. A staff member on duty incorrectly advised inspectors what settings the mattresses should be on. One person had sustained pressure damage earlier in the year. We made the provider aware of our concerns and they took immediate action to ensure airflow mattresses were on the correct setting and updated people's care records to reflect this.

● Risk assessments to enable people to smoke safely had not been completed. Risks such as the use of paraffin based emollient creams which pose a high risk of fire damage to a person had not been considered. One person who wished to smoke was prescribed paraffin-based emollient creams. Without robust risk assessments, people could not be assured of receiving the correct support to reduce the risk of significant harm.

● Risk assessments of the environment did not identify risks. For example, there was use of medicinal oxygen at the service, this was not highlighted as a risk on the fire risk assessment. Personal emergency evacuation plans (PEEPs) are used to help the emergency services and staff identify risks and people who would require assistance to evacuate in emergency situations. Without accurate information people may not receive timely assistance in an emergency. The file containing PEEPs were out of date. There were no PEEPs in the file for three people living at the service and file contained information of people no longer living at the service. The PEEPs summary sheet did not highlight the use and location of medicinal oxygen within the service. The provider updated the PEEPs file during the inspection.

There was a continued failure to ensure care and treatment was provided in a safe way or risks to people had been mitigated. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Safety checks of the premises had been carried out by contractors. For example, gas safety, water testing for Legionella and portable appliance testing (PAT).

Preventing and controlling infection

At the last inspection we found the service had failed to ensure appropriate infection control measures in response to the COVID-19 pandemic. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

● At the last inspection the service had not robustly considered the risks posed by COVID-19 towards people using the service. At this inspection we found significant improvements had been made to the cleanliness of the service and policies in respect of personal protective equipment (PPE) were being followed. However, there were some issues identified at inspection regarding vaccination status and test result record keeping.

● We were not assured the provider had a system in place to check the vaccination status of staff and visiting professionals in line with the COVID-19 government guidance. For example, the inspection team

were not asked to show proof of their vaccination status upon arrival to the service. The manager was unable to evidence checks had been made as to the vaccination status of an agency staff member who was working at the time of inspection. Contractors working on site told us they had been requested to show proof of their vaccination status. The management team had a system in place to evidence permanent staff vaccination statuses.
● We were not assured that the provider was preventing visitors from catching and spreading infections. The inspection team were not asked to show evidence of their negative lateral flow device (LFD) COVID-19 tests upon arrival to the service.
● We were somewhat assured the provider was facilitating visits for people living in the home in accordance with the current guidance. A relative told us staff were not consistent in requesting proof of their LFD test results. Where appropriate, people had allocated 'essential care givers'.
● We were somewhat assured that the provider was accessing testing for people using the service and staff. The manager was unable to evidence checks had been made as to the negative COVID-19 test of an agency staff member who was working at the time of inspection.

There was a continued failure to ensure appropriate infection control measures in response to the COVID-19 pandemic. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● 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. The service followed the latest government guidance in relation to testing and supporting people to isolate where appropriate.
● We were assured that the provider was using PPE effectively and safely. All staff had completed training for infection prevent and control, and COVID-19 awareness.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises. Housekeeping staff were guided by protocols and had check lists to ensure the premises was sanitised.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed. The provider had suitable protocols in place to prevent and manage infection outbreaks.
● We were assured that the provider's infection prevention and control policy was up to date.

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

Using medicines safely
At the last inspection there was a continued failure to ensure the proper and safe management of medicines. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

● At the previous three inspections the provider had been asked to make improvements to ensure medicines were managed safely. At this inspection no improvement had been made and further improvements were identified to ensure medicines were managed in a safe way.
● People did not always receive their medicines as prescribed. Some people required medicines that needed to be administered at specific times. Time-critical scheduled medicines are those where early or delayed administration may cause harm. However, records were incomplete, and we could not be assured people were receiving medicines as the prescriber intended.

● Staff had failed to administer two doses of one person's time specific medicine to treat the effects of Parkinson's disease. This was due to a supply issue which had not been identified until the point of administration. This could have an adverse effect on the progression of their condition.
● Some people were prescribed 'when required' (PRN) medicines. PRN protocols (documents to support medicine use) to guide staff on their usage did not always contain information as to why the person needed them or what the outcome would be. PRN protocols were not in place for all PRN medicines. Where a PRN medicine was used regularly this had not been escalated to the GP to review in line with best practice.
● Blood glucose monitoring machines were not calibrated to ensure that they were giving an accurate reading. This means that the staff may not be administering medicines based on accurate information

There was a continued failure to ensure the proper and safe management of medicines. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were told registered nurses underwent medicines competency checks online. Agency staff training was checked by the manager. Some team leaders who were not nurses were also trained to support with medicine administration and received a yearly refresher of all medicine training.
● Staff had access to the latest internal and external policies and procedures around the safe and effective use of medicines.

Learning lessons when things go wrong
● Accidents and incidents were recorded. There was a process to analyse accidents or incidents for trends, although identified actions to mitigate further incidents had not always been completed. For example, where a person had fallen from bed, actions included to lower their bed to the floor. This action had not been updated in the person's care records.
● There was a lack of lessons learned evident since the last inspection. Some of the concerns raised during our last inspection, included risk management and the completion of records in relation to people's care and support needs, however the service failed to address them. This has been further explained in the well-led section of the report.

Staffing and recruitment
● This inspection was partially prompted by concerns we had received regarding staffing levels.
● There were enough staff to meet people's everyday care needs. Where people required two staff to safely assist them, we saw this was met. Our observations confirmed staff were busy in the morning but were able to spend more time with people in the afternoons.
● Staff told us they worked well as a team. One staff member commented, "I believe we give good care, seems like we are short staff as we have a number of agencies. We worked with a girl yesterday, she was great."
● The service was experiencing a shortage of permanent staff at the time of the inspection; this was being managed and the service was actively recruiting. Agency staff were arranged to cover shortages and block booking of agency staff where possible, was carried out to provide a continuity of care.
● There were minor impacts on people, particularly with activities. A staff member told us, "Agency is high use at weekends - that's because previous management have allowed staff to have fixed rotas so it's hard to recruit because everyone has to have a fixed rota, only two nights with permanent staff and the rest are agency."
● Record keeping of staff recruitment was not in line with CQC's regulations. This has been further explained in the well-led section of the report.

Requires Improvement

Is the service effective?

Our findings

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

At the last comprehensive inspection 2 July 2019, this key question was rated as requires improvement. At the last inspection on 7 January 2021 this key question was not covered. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

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

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- The service did not always gain consent to care and treatment in line with the law and guidance.
- Where doubt had been recorded about people's capacity, the providers assessment and care planning was not robust to ensure people's capacity to consent to care and treatment had been considered in line with the Mental Capacity Act 2005. The providers assessment process and care planning failed to consider people's capacity to consent to care and treatment.
- Accurate, complete and contemporaneous records detailing the care and treatment provided to people had not been maintained and decisions relating to those were not effectively recorded. Some people at the service were not able to make decisions for themselves. Mental capacity assessments and best interests' decisions had not been completed. This meant the provider could not be assured people's human rights were being protected.
- The service had made applications to deprive people of their liberty without consideration to the principles of MCA. Best interest decisions had not been recorded and there was no rationale as to why DoLS applications had been submitted.
- Where a person had a granted DoLS authorisation, we found the conditions imposed by the local authority DoLS team had not been upheld or included in the person's care plan. The conditions were on place to improve the person's health and well-being.
- A person using the service was unlawfully deprived of their liberty. Mental capacity assessments had not

been carried out, although, the person's care plan stated they lacked capacity to make decisions. The care plan advised the person had a 'risk of absconding' and staff to 'ensure [person] is in the communal areas in the day where they can be monitored' and 'ensure the doors are locked.'
● MCAs and best interest decisions were not in place for people who lacked capacity and had bedrails in place. Bedrails pose risks for people who experience confusion and should be used with caution, people may be at risk of climbing bedrails and falling from height or become entrapped. Bedrails can also be considered a restrictive practice for people who are unable to consent to having them in place.

The provider had failed to consider and implement current guidance on the principles of the Mental Capacity Act (2005). This is a breach of Regulation 11 (Consent to care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We escalated our concerns to the local authority who confirmed people with a DoLS application will be prioritised for an assessment. The provider confirmed they will undertake appropriate MCAs for people immediately.

● Staff had received MCA training and demonstrated their knowledge by ensuring people were involved in making decisions. One staff member told us, "[Person] has declined to receive care in the past, we respected their wishes but try different tactics, 9/10 times we win them round."
● We observed staff obtaining verbal consent from people before providing support throughout the inspection.

Staff support: induction, training, skills and experience
● Staff did not always have the skills and experience to support people. One newly recruited staff member told us they had not received a formal induction and said, "I don't have a job description, I don't know what I am supposed to do; not great experience as a new person."
● Not all staff received essential training that met the providers training policy requirements. We reviewed 19 staff training records; staff had not completed diabetes training. Communication training had been completed by only 25 percent of staff, and there were further gaps contained in the training records. The limited training impacted staff knowledge on health-related matters in the absence of robust guidance and risk assessments.
● Staff told us, and records confirmed, one to one supervision had not been carried out regularly. One staff member told us, "No supervisions, I wouldn't mind taking criticism." We saw evidence of group supervisions being held, and staff told us they could approach the management when needed.
● Agency care staff had not always been fully inducted to the service. On the second day of the inspection, the manager had deployed an agency worker but failed to induct them prior to assisting people. Without an induction or clear guidance, agency staff may not assist people in their preferred way or understand people's assessed needs such as moving and positioning or eating and drinking.

The failure to ensure staff had the appropriate training and supervision to ensure people's needs were met is a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service employed trained nurses, who provided oversight to care staff. The trained nurses received clinical supervision by the management.
● Staff who were new to care completed the Care Certificate, a work-based, vocational qualification. New staff shadowed experienced staff until they were deemed competent and felt confident to work on their own.

● Staff told us they felt they had appropriate training to meet people's needs. Staff received training relevant to the people they supported. For example, dementia care and the mental capacity act.
● Most staff held a nationally recognised diploma in health and social care or equivalent. One staff member told us, "I am going to be doing my NVQ level two and three and I want to do my nursing. The manager said they would support me with this."

Supporting people to eat and drink enough to maintain a balanced diet; Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● This key question was last inspected on 2 July 2019. At that inspection provider did not always meet peoples' nutrition and hydration needs. People's preferences around food were not always adhered to. This inspection was partially prompted by concerns we had received regarding nutrition.
● At this inspection people's food preferences had been recorded and their wishes were respected. Preferences had been updated in people's care records and the kitchen staff were made aware of people's wishes. However, further issues had been identified regarding nutritional needs. People did not always receive effective nutritional support.
● People gave mixed feedback regarding the meals, comments included, "There is plenty of choice." And "The food is always cold."
● Where people had been identified as having lost weight, care plans did not guide staff on how to minimise further weight loss, to increase nutritional intake for the person or when to refer for professional involvement.

● People's needs had not always been assessed in line with standards and guidance.
● People's needs were assessed prior to admission to the service. The assessment forms were detailed in line with the Equalities Act 2010. Assessment forms were not always fully completed to contain information such as life histories, cultural requirements and sexuality, people's preferences had not always been recorded. This meant, staff would have limited knowledge to people's preferences upon admission.

We raised our concerns with the provider during the inspection. They confirmed they would review the guidance of people living with diabetes.

● Prior to the inspection we received concerns regarding food hygiene at the service. We these shared concerns with the food standards agency. The food standards agency undertook an inspection of the service on the 12 October 2021. They gave the service a rating of four out of five with recommendations about staff changing their clothes between providing direct care and preparing food. A chef had since been newly recruited to minimise care staff preparing food.
● Staff supported people with their meals and drinks. The dining room had been adapted into a second lounge, so people ate and drank in their armchairs or bedrooms. We observed a person being assisted by a staff member. There was positive communication during the assistance, an agency staff member continued the assistance midway through the meal which did not provide a continuity for the person. A review of this person's care records noted they preferred finger foods to enable them to eat without assistance.
● Pre-prepared lunches were obtained from a catering company which specialises in care home catering; they were served by the chef. The chef told us they were yet to complete IDDSI training, but they had researched food consistencies to ensure people's diets were appropriate.
● The chef told us they were aware of people dietary requirements and ensured sugar content was not too high. The chef advised people's diabetes were 'managed well'.
● People's dietary requirements were noted on a wipeable board in the kitchen. The chef advised the board

was updated when people's requirements changed or if people were newly admitted into the service.
● We observed people being offered choices for their meals. A choice of snacks and drinks were freely available throughout the day.
● We observed people enjoying their meals. One relative was pleased their family member had put a stone on since admission.
● A person was being supported to attend the dentist during the inspection.
● We saw examples where people were referred for professional involvement such as the chiropodist. Care records were not always clearly updated to reflect guidance, although, permanent staff were knowledgeable on people's assessed needs.
● Where people had new health needs, professional involvement had been sought. For example, where a person experienced constipation, the staff had contacted their GP for advice
● A person was being supported to attend the dentist during the inspection.

Adapting service, design, decoration to meet people's needs
● The adaptation and design of the service did not always meet people's needs.
● Where people had difficulties with their sight, there was a lack of consideration to their environment such as increased lighting. People did not have assistive technology, for example, talking books or clocks to support their needs.
● The service did not always meet the needs for people living with dementia. For example, there was limited signage around the service. Not everyone had their name, photograph or other sign to identify their bedrooms. The bathrooms were not clearly indicated with signage. This meant people were not always able to independently move around the service. We observed a person disorientated in the corridor; and required a staff member to guide them back to the lounge.
● We observed the environment to be worn but clean. Management told us, "This place is not perfect, but I can say the environmental changes is huge, I have been given the go ahead to get things fixed."
● People's bedrooms were neutrally decorated. We saw people had personal belongings, their photos and pictures had been fixed on the walls.

Following the inspection, the provider told us the environment would be improved to meet the needs of people living with dementia and visual impairment. They sent an action plan with timescales for this to be completed within two weeks.

Requires Improvement

Is the service caring?

Our findings

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

At the last comprehensive inspection 2 July 2019, this key question was rated as good. At the last inspection on 7 January 2021 this key question was not covered. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- People told us they were not always treated with dignity. One person told us, "There is no love, no compassion, no care." They described how a staff member had been abrupt with them.
- Where people's preferences had been expressed, these were not always met. For example, people were asked whether they would prefer a female or male staff member to support them. Due to staffing pressures, preferences could not always be upheld. The service's contingency plan for these events did not consider people's dignity nor appeared to have considered other options. In the event this could not be managed, the service had planned for two male assistants to support a person who requested female assistance.
- We observed a person with their bedroom door open, they were sitting in a wheelchair and their lower body was not covered in a dignified manner. We observed staff walking past the bedroom and saying good morning to the person. Staff did not attempt to ensure the person dignity. The inspector made a staff member aware of our observations. The care worker provided immediate support to reposition the person but failed to consider their dignity through ensuring their lower body was covered.
- Language used in people's care documentation was not always written in a dignified way or in line with the government guidance 'inclusive language: words to use and avoid when writing about a disability.' For example, people were deemed to be 'non-compliant' when they declined assistance or 'wheelchair bound' if they were a wheelchair user.
- The provider had not ensured staff had received training in privacy and dignity.

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

- People's relatives spoke highly of the care their loved ones received. Comments included, "Huge efforts made, some of the girls who work there are fantastic. Such a high level of caring." And "The care in the home is very, very good for the level of staff. I can't fault the carers, the staff that are there have been brilliant."
- Permanent staff knew people's preferences. On staff member gave examples of their knowledge of a person and told us, "With dinner, they like a cup of tea but also apples juice. I've got to know them well and their likes and dislikes, I always offer something different, we don't assume when giving choices."
- Staff told us they respected people's independence and preferences for support. One staff member gave an example when helping a person who was visually impaired. They told us, "This morning I helped [person] wash and dress, I always ask what they want to wear such as formal clothes or comfy clothes, I tell them

what colours they are. I ask what their favourite colour is, and I'll find them a jumper of that colour."

● We observed some positive interactions between staff and people. Staff treated people with kindness. People were asked what they would like for supper and were given a choice and time to answer. Another person was having difficulty opening a packet of biscuits, help was provided in a way that was respectful still enabled the person to finish the task independently once staff had slightly open the packet.

● People's diverse needs were documented, we saw where people had cultural or religious beliefs, these were recorded in their care records.

● All staff had received equality and diversity training.

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

● Where possible, people were supported to express their views and make decisions about their care.

● People were offered choices such as where they wished to spend time and what they wished to wear. One staff member told us, "[Person] has their own routine and how they like to be helped. We make sure we don't overstep the mark but are there when they need us."

● Relatives told us they were kept informed of changes to their loved one's needs. One relative told us, "They always tell me if there any problems like if my parent had fall, they are very good at letting me know." The relative continued to tell us they were involved in decisions for their family member.

● The service had designed a feedback questionnaire for people to complete. The survey explored people's preferences about films, music and books. This had been completed prior to the inspection and results were due to be analysed. The facilities manager told us the outcome would inform care planning and planning for various activities.

● People were supported to express their views; we saw evidence of people contributing to their care planning.

Requires Improvement

Is the service responsive?

Our findings

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

At the last comprehensive inspection 2 July 2019, this key question was rated as good. At the last inspection on 7 January 2021 this key question was not covered. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Meeting people's communication needs; Planning personalised care to ensure people have choice and control and to meet their needs and preferences
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.

- The service did not always demonstrate they met AIS. For people who had sight impairment, there was no guidance for staff to support them to read documents or letters.
- Documentation was not available in different formats such as large print, easy read or braille.
- The manager demonstrated their knowledge of AIS understanding of care providers responsibilities. The manager was unable explain what processes were in place in the service to ensure peoples communication needs were met. This is an area that requires improving.
- Where possible, we saw people were involved in their care planning. People were enabled to give their opinions, likes and dislikes.
- People's care plans included their wishes and goals as well as interventions to guide staff on how to support them. For example, a person who wished to spend most of their time in their bedroom had their wishes respected. This had been regularly reviewed with the person by staff to ensure their wishes were being upheld.
- All staff had received training on person centred care.

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

- This inspection was partially prompted by concerns we had received regarding the lack of activities for people.
- People were not always supported to follow interests socially and culturally relevant to them.
- There were few planned activities within the service. We observed people lacked occupation, stimulation and told us they were bored. One person told us, "There are no activities going on, the carers are doing their best." A relative told us, "All the residents that knew the activity lady loved her, it was a blow when she left."
- During both afternoons of the inspection, we observed people were engaged and enjoying various activities held by care staff. People were colouring, reading and listening to music. A relative brought in some reminiscence items which sparked conversation with people.
- Visitors were welcomed to the service and people could go out with them. We observed one person going out for lunch with a family member. One relative told us, "I visit, I book by appointments, it is quite efficient."

● People were supported to maintain relationships with friends and family. Some people had their own telephones to keep in contact with friends and families. One person had satellite television installed so they could follow their own interests. One relative told us the service had arranged a birthday party for their loved one.

Improving care quality in response to complaints or concerns

● The service responded to complaints or concerns.

● We received mixed feedback from relatives. One relative told us, "I'm not happy with the lack of response of my complaint about the maintenance of the premises." Another relative was mostly satisfied with an outcome of their complaints and told us, "Complaints have been hit and miss. I write emails and I wonder if the complaint has been lost in the manager's mind." They confirmed their complaints had since been resolved.

● We viewed the complaints log which showed one complaint had been received in the past year. Following discussion with relatives, it was disclosed further complaints had been submitted to the service. Upon review we saw the complaints had been investigated and concluded under the provider's safeguarding protocol.

End of life care and support

● At the time of the inspection, the service was not supporting anyone at the end of life stage.

● Staff took time to speak with people about their end of life wishes, these were recorded in their care plans. Where people preferred not to discuss this, their wishes were respected.

Inadequate

Is the service well-led?

Our findings

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

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care
At our last inspection, the provider's quality assurance system needed to be further developed to identify areas for improvement and fully embed these into practice. This was a breach of regulation 17 Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, not enough improvement had been made and there was a continued breach of this regulation.

● At the last inspection, the provider's systems and processes for quality monitoring had failed to identify significant concerns. This was in relation to keeping people safe, medicines, person centred care, provider oversight, management, staffing and the culture of the service. Enforcement action was taken against the provider and conditions were placed upon the providers registration. Subsequent to the inspection the provider engaged a consultant to address the concerns with the clinical governance of the service.
● At this inspection we reviewed the conditions imposed on the providers registration. We reviewed the report on actions the provider sent us each month against the action taken within the service. The conditions had been complied with; however, the provider had not initiated improvements identified in their actions plans.
● During the inspection, the management team was unable to evidence that a formal strategy or development plan was in place to address the failings from the last inspection. The provider was using the monthly conditions monitoring imposed by CQC to address concerns but had not implemented a strategy to drive service improvements.
● The provider did not regularly visit the service, which impacted on the oversight and governance of the service. The manager and newly recruited deputy manager told us they were not clear on what their roles or responsibilities were. Neither had been inducted to use the electronic care planning system. The manager had devised a list of responsibilities which did not cover aspects of the conditions imposed. There was no clear direction from the provider as to what was required of the manager and deputy manager to drive service improvements.
● Quality assurance systems for medicines and care planning records did not highlight issues identified. Medicines were not always stored or recorded appropriately in line with best practice. The monitoring and ordering process for medicines was not robust. We saw people going without medicines due to stock levels not being checked and therefore able to be ordered in an appropriate time frame. We could not be assured

the provider was ensuring the individual medicine needs of people were being identified and supported.
● The provider conducted medicines audits, learning from these audits was not always actioned and shared with staff. This meant that the provider could not be assured that people are being protected from known risks.
● Auditing of care plans did not always identify the specific medicine requirements or health conditions of people in the service. For example, people who took anticoagulants (blood thinning medicines) did not have specific instructions in their care plans to guide staff what urgent actions they should take if they sustained an injury. People who take anticoagulant medicines are at higher risk of excessive internal and external bleeding should they sustain an injury.
● People did not always receive person-centred care which gave them choice and control. One person experienced a health condition which resulted in extreme pain. The condition was noted in the person's care plan but there was a lack of detail of how the person wished to be supported. For example, how the pain could be avoided, the area of the pain, frequency of pain or guidance for staff to take caution when assisting them with moving and positioning. There was no information to guide staff of when to contact professionals for advice.
● Where a person was documented to be 'non-compliant,' interventions in their care records guided staff to hoist them to 'avoid injury'. The person was able to stand and weight-bare, a person-centred method would consider alternative approaches in accordance to their individual needs.
● The service did not always promote an inclusive culture for people. People were not consistently given opportunities to express their views on the service in order to aid improvements. Staff told us they attended meetings on an ad hoc basis, but they were not regular.
● Quality assurance processes had not identified that do not attempt cardiopulmonary resuscitation (DNACPR) were not completed appropriately by professionals. There were four examples where DNACPR forms had not been completed correctly. This meant staff could not be clear whether to resuscitate a person was in line with their wishes or in their best interests.
● Quality assurance processes had failed to identify incomplete legal documents. For example, we saw a range of documentation requesting consent from people for other reasons, such as, sharing information with professionals. There were inconsistently completed, some had been signed but others had not, there was no evidence of a person's lasting power of attorney consenting on their behalf.
● The provider had not followed CQC regulation respect of recruitment, which posed a risk of employing unsuitable staff. The files of two newly recruited staff did not evidence DBS checks or nursing and midwifery council (NMC) checks, there was no documented evidence of an interview taking place, no employment history check, or references. For example, a staff member commenced employment with the service in September 2021, their references were dated from 2020. When this was discussed with the management, they were not aware of any operational checking processes.
● We requested an online search with the management and found both staff members were registered with the NMC and the DBS update service without any restrictions of practice or convictions.
● There had been a high turnover of managers for the service, there had been four management appointments in the past two years. One relative told us, "There have been changes within the management, I have not always been kept informed."
● There was no registered manager in post at the time of the inspection. The newly recruited manager resigned midway through the inspection. We received a management plan shortly following the inspection to advise us of new management appointments.

Managers and staff were not always clear about their roles and understanding regulatory requirements. The provider had not ensured there were adequate systems to assess, monitor and improve the quality and safety of services provided, including risks to the health, safety and welfare of people and others. This was a continued breach of Regulation 17 Good governance of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

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

At the last inspection we found the provider had failed to notify CQC of relevant incidents that affect the health and safety and welfare of people using the service. This was a breach of Regulation 18 of Care Quality Commission (Registration) Regulations 2009.

At this inspection, not enough improvement had been made and there was a continued breach of this regulation.

● Services that provide health and social care to people are required to inform CQC of important events that happen in the service in line with regulatory requirements. The provider had not always informed CQC of significant events in a timely way.
● Following a review of DoLS authorisations, we found several examples where the provider had failed to notify CQC of events in the service. The provider's DoLS policy was clear about when to send notifications, but this had not been followed. Inspectors had identified this during a previous inspection.
● Management understood their responsibilities under the duty of candour. They described their obligation to be open and honest with people and provide an apology if something were to go wrong. We saw a documented example of where this had applied.

The provider had failed to notify CQC of relevant incidents that affect the health and safety and welfare of people using the service. This was a continued breach of Regulation 18 of Care Quality Commission (Registration) Regulations 2009.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics;
● People, their relatives and staff were not always been fully engaged and involved by the service.
● We received mixed feedback from relatives. Some told us they were comfortable to approach management and staff with comments and suggestions, others had little confidence in the provider. Comments included, "I am happy to give feedback and I feel they would listen." And. "I have emailed the powers that be that run the home, I never get a phone call back, I met the owner once, I explained how I felt, they did nothing about it."
● Relatives told us they were usually involved in their loved one's care. They confirmed they were kept up to date with changes to people or with the service. One relative told us, "With the current management we were kept up to date, they can contact us by email or phone if they have concerns. I am kept in the loop now, its improved."
● The service sought views from relatives, although formal surveys had not been distributed for over a year and a half. One relative told us, "We had been sent feedback questionnaires, they were once every couple of months. I haven't had any recently but before the pandemic we use to get them frequently."
● Staff told us they felt confident to approach management with feedback. Comments included, "Never had an issue with management, I feel I could approach them, they are always there if I need something." And, "I would trust that [manager] would look into any problems for me."
● Staff told us they were kept informed of changes to the service via a social media group chat, they said this was a good way of communication.

Working in partnership with others

● The service worked with health and social care agencies. When identified, people had external professional involvement including, GPs, SaLT and tissue viability nurses (TVN).
● Health and social care professionals gave feedback on the service provided to people. Comments included, "I have found the clinical care of patients to be of a high standard in my experience, and the nursing team carry out my requests for action promptly." And, "I appreciate there have been a number of changes in the management team, but the clinical care has been excellent throughout in my view."

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to consider and implement current guidance on the principles of the Mental Capacity Act (2005). Where consent had been provided on a persons' behalf processes were not in place to ensure the person providing consent had the legal authority to do so. This is a breach of Regulation 11 (Consent to care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider's processes did not ensure the right level of scrutiny and oversight to ensure people were protected from restrictions. This was a continued breach of regulation 13 (safeguarding people from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure staff had the appropriate training and supervision to ensure people's needs were met. This is a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service had failed to ensure appropriate infection control measures in response to the COVID-19 pandemic. There was a continued failure to ensure the proper and safe management of medicines. There was a continued failure to ensure care and treatment was provided in a safe way or risks to people had been mitigated. These were a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Managers and staff were not always clear about their roles and understanding regulatory requirements. The provider failed to ensure imposed conditions were met. This placed people at risk of potential harm. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Warning notice