Sidmouth Care Limited

Vale View Heights

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Vale View Heights is a residential care home providing personal and nursing care to 32 people at the time of the inspection. The service can support up to 55 people. The service provides accommodation over two floors in a large, extended building set in mature grounds with views over the Sid Valley. Many bedrooms have en-suite facilities, and some have patio areas or balconies overlooking the gardens.

People's experience of using this service and what we found
People's individual risks were not always effectively monitored and managed, and some care plans lacked detail about how to manage people's clinical conditions. Where people were being assisted to reposition, records were not consistently completed so it was not possible to know if they had been assisted at appropriate intervals. Application of people's prescribed creams was not consistently recorded.

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

Systems had not been put in place to ensure people's rights were protected under the Mental Capacity Act. At the time of inspection, staff and management were not clear who was being deprived of their liberty, which applications had been made and which had been approved. Audit systems had not identified inconsistencies and errors within care plans. No mental capacity assessments had been completed in advance of applications to deprive people of their liberty, nor had they been reviewed or completed since this was identified during our last inspection.

Some systems and processes had been introduced at both management and provider level to monitor quality performance. However, these were not yet embedded and were not robust. They did not always identify where improvements were required. Care records were not being consistently completed, and so it was not possible to audit them effectively. For example, one person had no care records recorded on a total of eight days in November 2021, and a second person had no care notes recorded for six days.

People living at Vale View Heights had care plans in place, however, these did not always contain sufficient detail and the care received did not always reflect their personal preferences. Four people we spoke to raised concerns that they were not able to have a bath or shower when they wanted one. Records showed that people were being assisted to have baths or showers and staff told us people would be assisted at a time of their choice. The manager told us they would address the feedback from people.

Care plans contained limited information about people's wishes as they neared the end of their life, however, we had not received any concerns about the care people received at the end of their lives and the service worked with other health professionals where appropriate. One bereaved family thanked the staff for the care they gave their loved one at the end of their life. They said, "I cannot express how much you assisted

at a very difficult time. He was kept comfortable and pain free."

People and their families told us they felt safe at Vale View Heights. One person said, "I still have some of my independence but there's help around if I need it. I feel very safe here." Staff were recruited safely and there were enough staff to meet people's needs.

New electronic systems had been introduced to assess risks to people, and assessments had been completed. Work was ongoing to ensure these risks were reflected in people's care plans. There was up to date documentation related to the safety and suitability of the premises. This included fire, gas and electrical safety checks and water temperature checks. Equipment used to assist people had been serviced.

Improvements had been made to infection prevention and control, and we were assured that current UK Government guidance was being followed. Changes were being made to ensure it would be easier to reduce the spread of infection, such as caring for people with similar needs in the same part of the building, meaning staff could co-hort more effectively in the event of an outbreak.

Systems had been implemented to ensure staff completed appropriate training. Staff had completed a range of essential training to ensure they were able to meet people's need safely. This was being supported with a developing programme of more specific and clinical training, such as diabetes management.

A new electronic care planning system had been introduced and went 'live' three weeks before our inspection. This system needed time to embed and to allow time for people's care plans to be developed to reflect their assessed needs and individual choices. People were asked what they would like to eat immediately before the mealtime and were offered a range of options. We received mixed feedback about the quality of the food. One person said, "The quality of the food is okay, but I think it could be better with a bit of imagination." Another person said, "It's okay and there is choice, but it should be better." People's needs were met by the adaptation, design and decoration of the premises.

People were treated with respect and kindness, and their privacy was respected. Staff were responsive to people's needs and addressed them promptly and courteously. Staff knew people well. For example, staff knew people's daily routines without referring to documentation. We observed many instances of genuine warmth between staff and people. People's families felt staff were caring. One told us, "All the staff seem friendly." Another family member told us their loved one says, "you couldn't have found a better home for me." We saw people being supported to express their views and make decisions regarding how they spent their day.

A new manager was in post and had applied to CQC to register. They had addressed a significant number of concerns identified at our last inspection in a relatively short period of time. The manager and provider had worked openly with both CQC and the Local Authority since the last inspection and were open and transparent about things that had gone wrong and the progress made. Quality assurance systems were being developed in order to maximise the effectiveness of the new care planning system. The regional operations manager, who was new in post, told us a system was being developed to ensure greater depth of regional and provider oversight. This included oversight of the quality and consistency of care plans.

The culture of the service had improved, and we received positive feedback from people, their families and staff. One person told us, "I think it's improved lately." A family member said, "The home seems in a better place now [manager] is there." And another said, "Compared to how it was before they have made wonderful changes." Comments from staff members included, "It's better now, it feels better going to work." "It's a happy home, nothing is too much trouble [for the manager], I think the residents are happier." "It's a

great place to work, the atmosphere is great. It's a happy home" and, "I think [manager] is amazing, she's putting in the right plans, stepping in the right direction, she really cares about what goes on here. It feels like she's really trying to build a team."

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
This service was registered with us on 02/09/2019 and this is the first five key question inspection.

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 sustained and the provider was still in breach of regulations.

Why we inspected

This inspection was carried out to follow up on action we told the provider to take at the last 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.

We have found evidence that the provider needs to make improvements. Please see the safe, effective 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 inspection, by selecting the 'all reports' link for Vale View heights 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 safe care and treatment, need for consent and good governance at this inspection.

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

Follow up

We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 always safe	**Requires Improvement**
Is the service effective? The service was not always effective	**Requires Improvement**
Is the service caring? The service was caring	**Good**
Is the service responsive? The service was not always responsive	**Requires Improvement**
Is the service well-led? The service was not always well led	**Requires Improvement**

Vale View Heights

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 carried out by two inspectors, a specialist nurse adviser 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
Vale View Heights 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.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed the information held on our systems about the service and monthly reports submitted to CQC since the last inspection. We reviewed information shared with us by the Local Authority. 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 eight people living at the home. We spoke with the providers representative, the regional operations manager, the manager and eight members of staff. This included nursing, care, maintenance and catering staff. We reviewed a range of records including two peoples care records, medicines records, audits and supervision records. We looked at documentation related to fire safety and the safety and suitability of premises. We also looked at three staff recruitment files and observed care in communal areas throughout the day. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

After the inspection
We continued to review documents remotely and seek clarification from the provider to validate evidence found. We reviewed three people's care records in detail and sampled a further six people's care records. We spoke with a further seven members of staff including care, administration, activities and housekeeping staff. We contacted seven health professionals for feedback and received a response from three.

Requires Improvement

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 now improved to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to ensure people were protected from receiving unsafe care and treatment, from avoidable harm or risk of harm. Risks to people's health and safety were not thoroughly assessed. 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.

- Risks were not always effectively monitored and managed.
- Some care plans lacked detail about how to manage people's clinical conditions. For example, one person was at risk of urinary sepsis, however, their care plan didn't contain enough information to support staff to manage their catheter care safely.
- People's risk of pressure damage was not recorded consistently in their care plans. For example, one person's care plan said they were 'at high risk of pressure ulcer' in one section, and 'there is no potential for wounds' in another. This could lead to confusion about their level of risk.
- Where people were identified as being at high risk of pressure damage, there was a lack of information about how often they should be assisted to reposition to reduce this risk.
- Where people were being assisted to reposition, records were not consistently completed so it was not possible to know if they had been assisted at appropriate intervals. For example, one person's records showed there were a number of occasions with no repositioning recorded for over seven hours, and on one occasion for over 23 hours.

We found no evidence that people had been harmed however, systems were not robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12, safe care and treatment, of the Health and Social Care Act (Regulated Activities) Regulations 2014.

- New electronic systems had been introduced to assess risks to people, and assessments had been completed. Work was ongoing to ensure these risks were reflected in people's care plans.
- People's 'summary care plan' contained good information about their clinical overview and any additional risks, such as diabetes or choking, that staff should be aware of.
- There was up to date documentation related to the safety and suitability of the premises. This included

fire, gas and electrical safety checks and water temperature checks. Equipment used to assist people had been serviced.

Using medicines safely

At our last inspection we recommended the provider consider current guidance on recording on how prescribed creams are administered and recorded and take action to update their practice. Improvements had not been made.

●Records did not demonstrate people received their prescribed creams at the appropriate times.
●Application of people's prescribed creams was not consistently recorded on either the paper medication administration records or the electronic records system.
●There were no body maps in place to indicate where creams should be applied, or clear instructions as to how often. Therefore, it was not possible to know if people had had their creams applied at the right time, and in the right place, or not.
●Records relating to time sensitive medicines were not always clear enough. For example, one person was prescribed a time specific medication, however, their medicines record only indicated 'breakfast', 'lunch' or 'tea' and no specific administration times were recorded. Another person's time specific medicines were recorded well with times of administration clearly recorded.

We found no evidence that people had been harmed however, systems were not robust enough to demonstrate medicines were effectively managed. This placed people at risk of harm. This was a breach of regulation 12, safe care and treatment, of the Health and Social Care Act (Regulated Activities) Regulations 2014.

●Paper medicines administration records were clear and changes to people's medicines clearly recorded.
●People's medicines were stored securely in a locked cabinet in their own bedrooms. Temperatures were checked to ensure medicines were stored safely.
●Competency assessments had been completed to ensure staff were administering medicines safely, and training was being sought for those that had not completed it within the past 12 months.

Preventing and controlling infection

At our last inspection the provider had failed to ensure people were protected from the spread of infection. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found improvements had been made.

●We were assured that the provider was preventing visitors from catching and spreading infections.
●We were assured that the provider was meeting shielding and social distancing rules.
●We were assured that the provider was admitting people safely to the service.
●We were assured that the provider was using PPE effectively and safely.
●We were assured that the provider was accessing testing for people using the service and staff.
●We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
●We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

●We were assured that the provider's infection prevention and control policy was up to date.
●We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to ensure systems and processes were operated effectively to protect people from abuse. This was a breach of regulation 13 (safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13.

●People told us they felt safe. One person said, "I still have some of my independence but there's help around if I need it. I feel very safe here."
●People's families felt their loved ones were safe at Vale View Heights. One family member told us, "I think she is very safe." Another said, "There is nothing that makes us feel he is unsafe."
●Staff had completed safeguarding training, and told us they felt comfortable raising any concerns, and were confident that management would take appropriate action.

Staffing and recruitment
●Staff were recruited safely and there were enough staff to meet people's needs.
●There had been a significant turnover of staff since the last inspection. Staff, people and their families commented that they would like to see a more consistent staff team embedded.
●People reflected that staff seemed rushed. One person said, "They have been so busy lately." Another told us, "The staff are so busy. I don't blame them; they try so hard but it's not good enough."
●We received mixed feedback from people's families when we asked if there were enough staff on duty. One person's family member said, "No, I don't [think there are enough staff]. I ring the bell and it takes ten to fifteen minutes for them to come." Another said, "I am very pleased they are coping as well as they are, they have done really well."
●The provider was actively recruiting new staff, including nursing staff, and using innovate methods to do so in a challenging market. This included providing accommodation for staff and applying for the appropriate licences to be able to recruit more widely.
●Appropriate checks were made prior to new staff starting employment.

Learning lessons when things go wrong
●Systems had been put in place to ensure lessons were learnt when things went wrong.
●Changes had been made in response to concerns identified at our last inspection. For example, a new computerised care planning system had been introduced to improve record keeping.
●Changes were being made to ensure it would be easier to reduce the spread of infection, such as caring for people with similar needs in the same part of the building, meaning staff could co-hort more effectively in the event of an outbreak.
●Falls and incidents were analysed to establish if any action could be taken to reduce the risk of the same thing happening again.

Requires Improvement

Is the service effective?

Our findings

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

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

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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.

At our last inspection consent form the relevant person was not always sought or recorded before providing care or treatment. This was a breach of regulation 11 (need for consent) 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 11.

- People's care was not always being provided within the principles of the MCA.
- At our last inspection we found that applications to deprive people of their liberty, and decisions about people's medical care, had been made without first assessing if people had the capacity to make the decision for themselves.
- At this inspection, we found that mental capacity assessments for two people had still not been completed, despite deprivation of liberty applications having been made in April and May 2020.
- Systems had not been put in place to ensure people's rights were protected under the Mental Capacity Act. At the time of inspection, staff and management were not clear who was being deprived of their liberty, which applications had been made and which had been approved. Audit systems had not identified inconsistencies and errors within care plans.
- On the day of our site visit, we were told three people were receiving their medicines covertly. No capacity

assessments had been completed in relation to these decisions. Following our site visit, we were told that a DoLs application had been made in December 2021 in respect of one of these people, however, a capacity assessment had still not been completed. We were told another one of the three people had full capacity.
●Following the inspection, we were provided with additional evidence. Two people had applications submitted to deprive them of their liberty in 2020. One of these applications was assessed and approved in March 2021. At the time of inspection both people's care plans reflected a lack of capacity. The manager has since told us these two people had been re-assessed in the weeks before our site visit, and were assessed to have capacity. No capacity assessments were completed. Applications were made in January 2022 to withdraw/end their DoLs, again, with no capacity assessments completed.
●The new evidence provided demonstrates a lack of understanding of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. We raised a safeguarding alert in respect of eight people.

The provider was not working within the principles of the MCA. This was a continued breach of regulation 11, safe care and treatment, of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● Our observations of staff interacting with people did not raise any concerns about their actions in the light of their responsibilities under the MCA. We observed staff facilitating people who did not possess mental capacity to make some decisions, for example, in what they ate and how they dressed.
●The manager told us that they had not had any reason to doubt the capacity of people admitted to the service since our last inspection, and that systems were now in place to assess people's capacity prior to making applications to deprive them of their liberty.
●Work was ongoing to implement and improve the new electronic care planning system and to ensure that each person's care plan accurately reflected their assessed capacity.

Staff support: induction, training, skills and experience

At our last inspection the provider had failed to ensure staff received appropriate support, training, professional development, supervision and appraisal. This was a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18.

●Systems had been implemented to ensure staff completed appropriate training.
●A training matrix had been developed and identified where staff still needed to complete training, such as medication.
●Staff had completed a range of essential training to ensure they were able to meet people's needs safely. This was being supported with a developing programme of more specific and clinical training, such as diabetes management.
●Regular face to face training had been introduced and staff were positive about the training they had attended.
●A supervision programme had been introduced and most staff had received two or three supervisions. Both one to one and group supervisions had taken place.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
●At our last inspection people's needs were not always fully assessed, care plans lacked specific details about people's care and inconsistent record keeping meant it was not possible for the service to demonstrate the delivery of care in line with expected standards.

●At this inspection we found improvements had been made, however, some care plans still lacked specific detail and record keeping required further improvement.
●A new electronic care planning system had been introduced and went 'live' three weeks before our inspection. This system needed time to embed and to allow time for people's care plans to be developed to reflect their assessed needs and individual choices.
●A staff member told us, "I'm getting used to new system, I think it's good. It makes care plans more accessible and I know where to find information."
●People's care plans were of varying quality. Some people had detailed profiles which gave staff an overview of what was important to them, other people's profiles had yet to be completed.
●One person's care plan contained no references to their learning disability, how this affected them and gave staff no guidance about how to communicate with them.
●Other people's care plans contained good detail about people's choices and preferred routines. For example, one person's care plan said, "[Name] spends a lot of her time watching the television, she likes films and will often watch till the early hours of the morning. Late nights and long lie ins in the morning suit her well."

We recommended that the provider ensure all care plans fully reflect people's assessed needs and choices.

Supporting people to eat and drink enough to maintain a balanced diet
●People were supported to eat and drink appropriately.
●We received mixed feedback about the quality of the food. One person said, "The quality of the food is okay, but I think it could be better with a bit of imagination." Another person said, "It's okay and there is choice, but it should be better."
●A family member told us, "She loves her food and her food is good. She has put weight on and at lunch she can have a glass of red wine."
●People were asked what they would like to eat immediately before the mealtime and were offered a range of options.
●Catering staff knew which people required modified diets and records reflected this.
●We observed staff supporting people to eat and drink in a relaxed and unhurried manner.

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 healthcare services where appropriate.
●One healthcare professional reflected that they felt the home was "moving in the right direction", but that it could sometimes be difficult to get hold of the right person when they call.

Adapting service, design, decoration to meet people's needs
●People's needs were met by the adaptation, design and decoration of the premises.
●There was appropriate signage to facilities such as toilets and bathrooms; communal areas such as corridors were decorated in such a way as to differentiate between areas of the home
●Plans were in place to utilise the communal space better and create a lounge/dining space on the lower ground floor.

Good

Is the service caring?

Our findings

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

At the last inspection this key question was not rated. At this inspection this key question has been rated good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

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

- People were treated with respect and kindness, and their privacy was respected.
- We observed good interaction between people and staff who consistently took care to ask permission before intervening or assisting.
- Staff were responsive to people's needs and addressed them promptly and courteously. Staff knew people well. For example, staff knew people's daily routines without referring to documentation. We observed many instances of genuine warmth between staff and people.
- One person told us, "The staff are really nice and caring here." Another person said, "The carers work so hard and most of them are lovely people."
- A person who had recently stayed at Vale View Heights for a short period of time said in an online review, 'All of the care staff are extremely professional and hardworking. Nothing is too much bother for them.'
- People's families felt staff were caring. One told us, "All the staff seem friendly." Another family member told us their loved one says, "You couldn't have found a better home for me."

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

- We saw people being supported to express their views and make decisions regarding how they spent their day.
- Where people were unable to make their own decisions about their care, their care plans contained information about who would help them make decisions or make decisions on their behalf.
- Care plans contained good information about some people's personal preferences and how they liked to spend their time. Other people's care plans were still being developed.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was not rated. At this inspection this key question has been rated requires improvement. This meant people's needs were not always met.

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

●People living at Vale View Heights had care plans in place, however, these did not always contain sufficient detail and the care received did not always reflect their personal preferences.

●Four people we spoke to raised concerns that they were not able to have a bath or shower when they wanted one. One person said, "I just don't get showers when I want them." Another said, "I have a problem getting a bath when I want." And a third said, "I couldn't say I have control when I can't have a bath when I want one."

●Records showed that people were being assisted to have baths or showers and staff told us people would be assisted at a time of their choice. The manager told us they would address the feedback from people.

●We observed people being supported to make choices such as what to eat, where to sit and what activities to take part in. One person said, "If you mean where I go and what I do, I have control."

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

●Two activities co-ordinators provided a range of group activities throughout the week. Some of these were based on people's individual hobbies, such as a knitting club for a small group of people who enjoyed knitting.

●Some people told us that they got bored, and that activities didn't always suit people's needs. One person said, "I do get bored, especially in my room. There are activities going on, but they are not my type of thing."

●People were supported to maintain relationships and arrangements were in place for families to visit.

●On the first day of our inspection we saw one person celebrating their birthday. Staff had decorated the lounge area with banners and balloons, and they enjoyed a visit from their family with presents and a cake.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

●People's care plans did not always contain sufficient detail about the support they needed to communicate.

●One person's care plan stated they had no speech, limited hearing and no vision. The care plan did not tell staff how to communicate with this person, or how to recognise if they were in pain. No pain assessment tools were in use.

●We observed staff taking time to communicate with people. One staff member used a menu to help people

choose what they wanted for lunch.

Improving care quality in response to complaints or concerns
●Systems were in place to record, review and learn from any complaints or concerns.
●People we spoke with were clear about who they could and should approach with any complaints. None had made any recent formal complaints.
●People's families told us they felt comfortable raising concerns. One family member said, "If I have had any concerns, I would see [Name] immediately."

End of life care and support
●Care plans contained limited information about people's wishes as they neared the end of their life.
●Some senior, nursing and care staff had completed end of life training, however, the majority of staff had not.
●We had not received any concerns about the care people received at the end of their lives and the service worked with other health professionals where appropriate.
●One bereaved family thanked the staff for the care they gave their loved one at the end of their life. They said, "I cannot express how much you assisted at a very difficult time. He was kept comfortable and pain free."

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question has now improved to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

At our last inspection effective systems and processes were not in place to asses and monitor the service. The culture and leadership of the home was not person centred, open, inclusive or empowering and did not lead to good outcomes for people. This was a breach of regulation 17 (good governance) 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 17.

●Some systems and processes had been introduced at both management and provider level to monitor quality performance. However, these were not yet embedded or operated robustly, and did not always identify where improvements were required.
●A report from November 2021 stated, 'All MCA's reviewed in readiness for transfer to [the electronic care planning system].' This review did not identify that two people did not have capacity assessments in place. One person's 'MCA' was marked as 'done', when there was none in place.
●A review of the new electronic care planning system reported, 'All care plan elements are now completed for all residents up to the basic standard.' This review did not identify the inconsistencies we saw in people's care plans or that some people had basic profile information missing.
●Care records were not being consistently completed, and so it was not possible to audit them effectively. For example, one person had no care records recorded on a total of eight days in November, and a second person had no care notes recorded for six days.
●Because care records had not been reviewed, inconsistencies and lack of detail in care plans in relation to risks around skin integrity has not been identified, nor had significant gaps in repositioning charts that were in place.

Systems and processes to assess and monitor the service were not embedded or operated robustly. This

was a continued breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●A new manager was in post and had applied to CQC to register. They had addressed a significant number of concerns identified at our last inspection in a relatively short period of time.
●The manager and provider had worked openly with both CQC and the Local Authority since the last inspection and were open and transparent about things that had gone wrong, and the progress made.
●Quality assurance systems were being developed in order to maximise the effectiveness of the new care planning system. The regional operations manager, who was new in post, told us a system was being developed to ensure greater depth of regional and provider oversight. This included oversight of the quality and consistency of care plans.
●The new care planning system had only been in place for a short period of time. Records relating to people's care had improved, however, they were inconsistent and required further improvement in order that people's care could be properly monitored.
●The new care planning system included a handover section, which had improved communication and meant staff could see any important changes or messages when they came on shift.
●Staff meetings and meetings with people's families had been held and information regarding the work taking place in the service communicated openly.
●The culture of the service had improved, and we received positive feedback from people, their families and staff.
●One person told us, "I think it's improved lately. It's such a shame what happened here. Everything was turned upside down. Hopefully, things are settling down now." Another person said, "Well, it's not perfect, but it's much better than it was. I like the manager and the girls are lovely"
●A family member said, "The home seems in a better place now [manager] is there." Another said, "Compared to how it was before they made wonderful changes."
●Comments from staff members included, "It's better now, it feels better going to work." "It's a happy home, nothing is too much trouble [for the manager], I think the residents are happier." "It's a great place to work, the atmosphere is great. It's a happy home." And, "I think [manager] is amazing, she's putting in the right plans, stepping in the right direction, she really cares about what goes on here. It feels like she's really trying to build a team."

Continuous learning and improving care; Working in partnership with others
●Significant changes had been made to the operation and leadership of the service in order to drive improvement.
●The provider had made investment into both systems and leadership roles in order to improve oversight and quality of care. They had increased their involvement and oversight of the service.
●Staff worked with other health professionals where appropriate and shared information where necessary.
●A visiting health professional told us they felt things were, "moving in the right direction."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider was not working within the principles of the Mental Capacity Act.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems were not robust enough to demonstrate safety was effectively managed. This placed people at risk of harm.

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 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Systems and processes to assess and monitor the service were not embedded or operated robustly.

The enforcement action we took:

We imposed conditions on the providers registration.