Alliance Care (Dales Homes) Limited

The Berkshire Care Home

Inspection report

126 Barkham Road
Wokingham
Berkshire
RG41 2RP

Tel: 01189770233
Website: www.brighterkind.com/theberkshire

Date of inspection visit:
21 March 2022
22 March 2022
23 March 2022
05 April 2022

Date of publication:
09 May 2022

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
The Berkshire Care Home is a care home with nursing that provides a service for up to 58 older people, some of whom may be living with dementia. At the time of our inspection there were 31 people living at the service. The care home is located in a residential area. Accommodation is arranged over two floors. There are a number of communal lounges and a communal dining area. There is a large garden surrounding the building.

People's experience of using this service and what we found
Changes were made to improve the safety of care people received. However, further action is required to ensure safe care is always provided. Some risks were found for night time care but the service had reacted to increase vigilance of support during these shifts. There was a dependency tool in place for determining the number of staff for shifts. Call bell audits were sporadic and analysis could occur more frequently to measure safe staff deployment. Recruitment files did not always contain all of the information required at the point of employment, however work was progressing on this. Incidents and accidents were logged, but there was some inconsistent recording and follow up. Infection prevention and control remained satisfactory. People were protected against abuse and neglect. Premises risks were assessed, however mitigation of risks was not always satisfactory.

People's needs were assessed by staff and reviewed regularly. Not all staff have completed mandatory training. Staff supported people to maintain an adequate dietary intake. Staff liaised effectively with professionals to meet people's health and wellbeing needs. The provider had not made any improvements to the premises to meet the needs of people living with dementia. Mental capacity assessments and best interest decisions were not always completed fully and effectively. Care plans did not always contain evidence of legally appointed representatives for people assessed as not having capacity. People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Some improvements to systems and processes were in place to ensure safe, compassionate, well-led care. Work on recruiting a new home manager was ongoing. Progress was being made towards compliance with the regulations in breach, but some breaches have continued at this inspection. The action plan was being used to track progress, as well as an electronic system of tasks. There is evidence of a programme of audits, completed at different intervals, however more time is required to embed the new system of audits and checks. There is evidence of meetings with people, relatives and staff. The clinical oversight by the clinical lead is well-managed and they are proactive at following up actions required by other staff members. Staff reported an improved workplace culture.

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 inadequate (published 7 January 2022) and there were nine breaches of regulations.

We served two warning notices against the provider and issued seven requirement notices. For the requirements notices, the provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection we found the provider had complied with some regulations but remained in breach of other regulations.

At our last inspection we recommended that staff receive additional training in safeguarding adults at risk and review how clinical staff work effectively with health and social care professionals. At this inspection we found the service made progress towards the prior recommendations.

This service has been in 'special measures' since 14 December 2021. During this inspection the provider demonstrated that some improvements have been made. Further improvements are required, as some regulations remain in breach.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 5 October 2021, 6 October 2021 and 12 October 2021. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve the safety of people, the effective of care and ensure the service was well-led.

We undertook this focused inspection to check they had followed their action plan and to confirm whether they now met legal requirements. This report only covers our findings in relation to the key questions Safe, Effective and Well-led which contain those requirements.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from inadequate to requires improvement. This is based on the findings at this inspection.

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

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 further improvements.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified continued breaches in relation to Regulation 11, Regulation 15, Regulation 18, Regulation

19 and a new breach of Regulation 12.

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

Follow up
We will request an action plan from 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 continue to monitor information we receive about the service, which will help inform when we next inspect. We will also continue to meet with the provider to discuss their progress towards achieving compliance with the regulations.

The overall rating for this service is requires improvement. However, the service will remain in 'special measures'. We do this when services have been rated as inadequate in any key question over two consecutive inspections. The inadequate rating does not need to be in the same question at each of these inspections to remain 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 six months to check for significant further improvements.

If the provider has not made enough further improvements within this timeframe, and there is still a rating of inadequate for any key question or overall, 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 further 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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

The Berkshire 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 Health and Social Care Act 2008.

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

Inspection team
The inspection team included three inspectors and a medicines inspector.

Service and service type
The Berkshire Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. The Berkshire Care Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

At the time of our inspection there was not a registered manager in post.

Notice of inspection
All dates and times of this inspection were unannounced.

What we did before the inspection

We reviewed information we already held and had received about the service since the time of the last inspection. We sought feedback from the local authority, safeguarding team and other professionals who work with the service. We checked information held by the fire and rescue service, Companies House, the Food Standards Agency and the Information Commissioner's Office. We checked for any online reviews and relevant social media, and we looked at the content of the provider's website. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do 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
The unannounced site visits were completed during both day and night hours. We observed people's care and staff interaction with them. Some people were not able to participate in a conversation with us. We wrote to the nominated individual and requested some information, which was received. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also wrote to the senior care quality manager to request evidence. We spoke with the managing director, regional manager, regional support manager, a peripatetic manager, interim home manager, another care home manager from the provider's services, care support manager and the clinical lead (deputy manager). We also spoke with four registered nurses, five care workers, the receptionist, the administrator, the activities coordinator, dining room assistant and the maintenance person. We reviewed a range of records. This included multiple people's care records, four staff personnel files and all medicines administration records. A variety of records relating to the management of the service, including policies and procedures were also reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We requested and received quality assurance documents and premises and equipment records. We contacted the service to ask further questions for outstanding matters.

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 our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was a continued risk that people could be harmed.

At the inspection on 5 October 2021, 6 October 2021 and 12 October 2021, there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered person had not ensured risks to the health and safety of service users were effectively assessed and mitigated. We served a warning notice against the provider.

Assessing risk, safety monitoring and management

- During the unannounced night visit, we found some people did not have call bells and fluids within reach. We advised the management team who acknowledged our finding. They took action to increase vigilance of people's safety at night, including creation of a new tool to spot check people's bedrooms.
- Some people's beds were low to the floor, to reduce the risk of injuries if they rolled out of bed. Crash mats were positioned on the floor next to their beds. Where they had bed rails, they were raised and bumpers correctly applied. Air mattresses to prevent pressure ulcers were functioning and set at the correct level.
- Crash mats and sensor mats were located appropriately in people's rooms. This ensured if they rolled out of bed or stood up that an alarm would alert staff and they could attend to the person.
- There were suitable records of people's care during the night, including welfare checks, fluid charts and turn charts. The regional support manager stated that some gaps were possible in the records; we found a few gaps in the documentation, but this did not place people at direct risk of harm.

Enough improvement was made and the provider was no longer in breach of this part of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are satisfied the provider has complied with the warning notice at this inspection, however further improvement is still required as per the bullet point above.

- We carried out a tour of the premises and observed some items were stored under the stairs and where the fire equipment was stored, blocking access to it. The management team was notified, and the items were removed immediately. We observed these areas at various times throughout our inspection and it was kept clear.
- We also found a bathroom and linen storage with some unnecessary items stored such as people's unused equipment, red bags, and other domestic items. We asked the management to take action to address this.
- We advised the management that outside there was a large pile of combustible items stored directly against the side of the building creating a fire hazard. This was addressed during the inspection to remove items and put them in the skip.
- We observed the testing of the fire alarm. The dining room and activity room were separated by double

doors, one of them closed automatically. The other door was propped open with a door wedge and did not close. We noted this to staff who removed it and closed the door.
● People were not always protected against environmental risks to their safety and welfare. We looked at fire and water safety checks. Not all records were consistently filled in. For example, records for quarterly fire safety system checks, carbon monoxide and water temperature measuring device calibration were blank without explanation.
● We reviewed the fire and Legionella risk assessments where multiple actions and recommendations were noted. Some of the observations recorded matched our findings such as inappropriate storage of a variety items such as equipment, PPE and risk of fire due to combustible items being stored in various parts of the building.
● We have shared our findings pertaining to fire safety with the local fire service.

There were risks to people, staff and others from the premises that were not effectively mitigated. This was a new breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 at this inspection.

Staffing and recruitment
At the inspection on 5 October 2021, 6 October 2021 and 12 October 2021, there was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered person had not ensured staff were effectively deployed.

● The service continued to use a dependency assessment for each person to determine their level of support required. For example, the tool assessed people's needs for breathing, moving and handling, nutrition and skin integrity. Criteria guided nursing staff how to score each area of need.
● The dependency tool was updated monthly. Scores from the tool were entered into a single calculator operated by the management team. This provided a suggested amount of staff to be deployed on each shift.
● We checked rotas, allocation sheets and observed the number of staff deployed on various shifts including night-time. At peak times such as morning hygiene and lunch service, staff were observed to be busy but there was no evidence that people were at risk of harm. At other times, staff were observed to attend to people's needs promptly.
● The service continued to experience vacancies in the permanent nursing workforce. The provider had mitigated the risk by filling shifts with agency workers, many of whom were 'block' booked in advance.
● Call bell wait times were not routinely monitored. There was some evidence of extended waits for staff to attend to call bells, but they were limited. This was supported by comments in a 'residents' meeting which mentioned sometimes waiting for staff when a call bell was pressed. The management team had documented in daily meeting notes reminders for staff and actions needed to ensure call bells were answered promptly.

Enough improvement was made and the provider was no longer in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 at this inspection.

At the inspection on 5 October 2021, 6 October 2021 and 12 October 2021, there was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered person had not ensured recruitment procedures were established and operated effectively to ensure only suitable staff were employed. They failed to ensure all information required in Schedule 3 of the regulations was available.
● Personnel files we checked contained some continued gaps in the information and missing documents required by the regulation and schedule.

● We provided a list of unavailable documents to the management team, who gathered them and sent us copies after our scrutiny of the personnel files.
● The management team explained an HR business partner previously completed a 'spot check' and found issues with the content of some files. They then proceeded to complete an audit of all personnel file content.
● They provided us with a copy of their findings. Three staff did not have copies of their criminal history checks on file. Multiple files did not contain sufficient checks of prior conduct of some staff members. The provider was taking action to address the findings and obtain the documentation.
● However, at the point of employment, the provider did not have all of the necessary documents required to ensure staff employed were 'fit and proper'.

The registered person had not ensured recruitment procedures were established and operated effectively to ensure only suitable staff were employed. This was a continued breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 at this inspection.

Using medicines safely
At the inspection on 5 October 2021, 6 October 2021 and 12 October 2021, there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered person did not ensure the proper and safe management of medicines.

● We observed staff give medicines to people in the morning. The staff were polite, gained consent and signed for each medicine after giving it on the medicine administration record (MAR).
● Medicines including controlled drugs (those subject to strict requirements) were stored securely and at the appropriate temperature.
● Medicine reviews were carried out by clinicians from the local GP practice. However, reviews were not always recorded appropriately. This meant we could not verify if these were carried out at regular intervals and for everyone living at the home.
● We found syringe drivers which had not been calibrated as per the manufacturer's instructions. A syringe driver is a small portable battery-operated pump that administers medicines by continuous infusion. Also, the staff did not quality check blood glucose monitors as per the manufacturer's instructions. This meant there was a risk equipment used for administering palliative care medicines and monitoring blood glucose levels may not work as intended. We highlighted this to the management team. They took prompt action to address the issues and submitted the evidence to us.
● Three people were prescribed palliative care medicines for end of life. There was no information in the care plan for staff as to what medicines were prescribed and when to initiate these medicines. For another person who was prescribed insulin, their diabetes care plan did not state the dose of insulin prescribed to them. For another person who was prescribed an anticoagulant, the care plan did not provide information to staff on how to monitor and manage its side effects. Anticoagulants are medicines that help prevent blood clots.
● Medicines administration records (MAR) were not always in place for all prescribed medicines. For one person who was prescribed palliative care medicines for end of life, there was no MAR in place for staff to administer these medicines. For another person their medicine was changed from three times a day to be given on a 'when required' basis. However, the staff did not have the current MAR in place. This meant there was a risk the staff may not be able to administer medicines as prescribed.
● This was raised with the care home support manager who provided evidence that action was taken to remedy the missing information and care plans.
● The staff received training and were competency assessed to handle medicines. However, there were still some staff members whose competency had not been assessed as per provider's own policy.

Enough improvement was made and the provider was no longer in breach of this part of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are satisfied the provider has complied with the warning notice at this inspection, however further improvement is still required as per the bullet points above.

Learning lessons when things go wrong
At the inspection on 5 October 2021, 6 October 2021 and 12 October 2021, there was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered person failed to evaluate and improve their practice in respect of the processing of information related to accidents and incidents. We served a warning notice against the provider.

● All accidents, incidents, near misses and concerns were recorded on the online system. The details of incidents and immediate support provided were noted. However, the registered person did not ensure records of all actions and tasks were recorded consistently.
● The system had parts to complete such as details of any lessons learned, good practice and prevention of similar incidents. However, this was not completed consistently even though the records were open for a while. The recordings were inconsistent, lacking detail of the investigation or root cause analysis. The records were not always signed off to indicate the management at that time had reviewed it. They did not look at individual risks and patterns nor did they highlight any action as a result to prevent recurrence.
● The service had a new clinical lead and the interim manager, and some actions were assigned to them to review and update the system. At regional level, the provider did not proactively review and monitor the progress of the incidents, accidents and other concerns reported so that trends, themes, lessons and prevention could be identified effectively.
● This did not support the management team in the service to concentrate on addressing other priority issues such as people's care and support, consistency with their records and improving staff culture and practices in the service.

Enough improvement was made and the provider was no longer in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are satisfied the provider has complied with the warning notice at this inspection, however further improvement is still required.

Systems and processes to safeguard people from the risk of abuse
● People were protected from harm, neglect and discrimination. Relatives and professionals felt they were safe at the service.
● At the last inspection we made a recommendation about staff training in safeguarding. An improvement was made. Staff received training in safeguarding adults at risk. Staff were aware of the provider's whistleblowing policy and when to raise concerns about care practices.
● The nominated individual explained they took whistleblowing seriously and detailed actions they took if allegations were raised by staff or others.
● Staff were confident the management team would act on any concerns reported to ensure people's safety.
● The management team reported allegations of abuse or neglect to the local authority, so they could be investigated. There were some ongoing safeguarding cases at the time of inspection and the management team was working on these with the local authority.
● We received notifications from the service where allegations of abuse or neglect were made. We directed the service to send one which was not reported, and we received it. The matter was already under review by the local authority.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● The service's visiting arrangements aligned to the government guidance in place at the time. This included using a PPE station and testing facility at reception. Visitors, contractors, professionals were also asked to sign a declaration form and check their temperature on arrival. In addition, hand gel was available and used on arrival. Visitors were required to wear a face mask at all times.

Inadequate

Is the service effective?

Our findings

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

At our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
At the inspection on 5 October 2021, 6 October 2021 and 12 October 2021, there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered person had not effectively assessed and mitigated risks to the health and safety of service users. We issued a warning notice against the provider.

- Further improvement is required to ensure robust assessment of people's needs and choices.
- Risk assessments were carried out for areas such as nutrition, skin integrity, falls, and these were reviewed regularly. Staff described how they managed risks to people's care and support and sought professional advice and help as and when needed.
- The clinical lead showed their involvement in ensuring risk assessments and care plans were updated on a rolling basis.
- Assessments of people's needs were not always effectively completed or recorded by staff. Care plans contained unclear information about people's needs.
- Care plans for specific conditions were divided into two areas; 'Assessed Needs' and 'Expected Outcomes'. People's needs and outcomes were not always clearly identified. A person living with Parkinson's disease required their medicines to be given at specific times to help manage their symptoms. In the 'Assessed Needs' section of their care plan staff had written: "[Person] can have episodes of being stiff. [Person] can have episodes of shakes or shaking. [Person] sometimes has episodes of being very sleepy [Person] needs to receive his medication in time. [Person] needs to maintain a regime of medication. [Person] gets episodes of being stiff."
- Although the care plan did identify the person's need to receive their medicines on time, the reasons for this were not clearly documented. This placed the person at risk of not having their symptoms managed effectively.
- Another person was at risk of malnutrition. In the 'Assessed Needs' section of their care plan staff had written: "[Person] has recently lost an enormous amount of weight unintentionally. [Person] is already under the care of the dietician. No cause for the weight loss has been established." This placed the person at risk of unsafe care due to staff having unclear information about their needs.
- Another person had considerable pain after suffering a stroke. There was no evidence of a care plan for pain assessment and management in their documentation. This placed the person at risk of experiencing pain not satisfactorily managed.

Enough improvement was made and the provider was no longer in breach of this part of Regulation 12 of

the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are satisfied the provider has complied with the warning notice at this inspection, however further improvement is still required.

● Staff had made improvements to care plans and records for people living with diabetes.
● Care plans for people living with diabetes included specific guidance for staff on managing their condition. People's blood glucose levels were monitored consistently. Care plans contained guidance for staff about what to do and when to seek medical advice if people's blood sugar levels were too high or too low. The provider did not have a policy in place for diabetes management.
● For people who had wounds staff had included relevant information on care and treatment in their care plans. Evidence showed staff had documented dressing changes and treatments administered for wounds.

Supporting people to eat and drink enough to maintain a balanced diet
At the inspection on 5 October 2021, 6 October 2021 and 12 October 2021, there was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered person had failed to have regard to people's wellbeing when meeting their nutrition and hydration needs.

● We observed people's lunchtime in the dining room. Quiet music was playing and the dining room was full of people.
● People were seated in small groups. If people did not want to eat the meal on offer staff asked them if they would prefer an alternative. One person wanted to join the meal after the mealtime had started. Staff supported the person to choose a seat of their choice.
● Where people required assistance to eat staff were supporting them. People were given specialised cups, crockery and cutlery as needed.
● Staff spoke calmly and quietly to maintain a calm and pleasant atmosphere for people.
● People's risk of experiencing malnutrition or inadequate hydration was assessed by staff. Care plans contained appropriate assessments and records of food and fluid intake. People's food preferences were also recorded. Staff supported people to eat and drink enough to maintain a healthy diet.

Enough improvement was made and the provider was no longer in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in this key question at this inspection. The prior breach of Regulation 9 in key question Responsive has not been inspected, and therefore remains in place until the next inspection.

Staff support: induction, training, skills and experience
At the inspection on 5 October 2021, 6 October 2021 and 12 October 2021, there was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered person had not ensured staff were suitably qualified, competent, skilled and experienced to carry out their roles effectively.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 18.

● Staff in management roles had not received regular supervisions. The home's clinical lead had been at the service for six weeks and had not received any supervisions. After we pointed this out, the interim home manager completed one-to-one sessions with the department heads.
● The provider's matrix for mandatory training showed 26 out of 39 staff members had not completed their mandatory training.
● The service had not arranged training for staff to enable them to meet the needs of people living with

specific conditions. We requested evidence of training for staff in specific areas such as diabetes care and Parkinson's disease care. The management team provided evidence after the site visit that only one registered nurse and four care workers had completed training for management of diabetes in 2020 and 2021. The remaining staff who supported people had not completed additional training, even such training topics were available from the provider.

The registered person had not ensured staff were suitably qualified, competent, skilled and experienced to carry out their roles effectively. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff told us they were supported by the management team and were receiving some regular supervisions. This was confirmed in records we reviewed.
● A series of staff training webinars for supporting people with various clinical conditions were available, and the interim home manager planned to enrol staff in relevant topics.

Adapting service, design, decoration to meet people's needs
At the inspection on 5 October 2021, 6 October 2021 and 12 October 2021, there was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered person had failed to ensure the premises were suitable for people living with dementia.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 15.

● The service had not done all reasonably practicable to ensure the environment was suitable for people living with dementia. The environment did not enable people to maintain their independence and dignity for as long as possible.
● The managing director and interim home manager stated an audit of the environment had been completed to assess its suitability for people living with dementia and identify improvements which needed to be made.
● However, this was only completed in February 2022. Our final inspection report was sent to the provider on December 2021, where we had pointed out the environment was not suitably decorated and adapted and the regulation was in breach.
● People could become disorientated and confused by the existing colours and patterns of walls, floors and corridors in the home which were not decorated for people living with dementia. We observed the use of pale colours throughout the building which did not assist people living with dementia to effectively orientate themselves.
● People's continued continence may not be promoted and maintained due to the lack of colour contrast on toilets and bathroom fittings. Not all toilets had contrasting toilet seats and handrails. The audit stated all toilets in the building should have contrasting toilet seats and handrails. Ensuring good colour contrast on bathroom fittings makes toilets and basins easier for people living with dementia to see and use.
● Good lighting helps people with dementia see where they want to go and to identify spaces, rooms, equipment and signs. In addition effective lighting enables people to see others clearly including their face and body language. We observed hallways were dimly lit, even when lights were all turned on. Poor lighting in these areas increased the risks of falls.
● People's independence can be supported by using correctly positioned signs and symbols to help them identify different rooms, areas, and to navigate around the building. There was insufficient use of symbols, and signs were not suitably placed. The provider planned for bespoke signage.
● Best practice evidence from the King's Fund, states clutter and physical distracting objects cause added

confusion for people living with dementia and should be avoided. Some areas in the home remained cluttered with objects, such as the communal conservatory. Communal bathrooms contained stacks of clinical waste bags, laundry bags, and personal protective equipment.

The registered person had failed to ensure the premises were suitable for people living with dementia. This was a continued breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

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

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

At the inspection on 5 October 2021, 6 October 2021 and 12 October 2021, there was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered person had failed to keep complete and accurate records of consent and decisions made by people or on their behalf in their best interests.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 11.

● Staff had received extensive training, including support from the local authority, to assess people's capacity to make decisions about their care and support. However, records showed staff were not completing assessments effectively. For example, some people were able to make choices about what to eat, wear or which activities to take part in but they did not have the capacity to make decisions about which healthcare treatments they needed or where they should live. This information was not effectively assessed by staff in the assessments in people's care plans.
● Care records showed staff had made 'blanket' assessments of people's capacity, concluding they were not able to make any decisions about how and where they received their care and support. In one person's capacity assessment staff had stated written, "[Person] does not have capacity to make decisions regarding living at the Berkshire care home, when he needs personal care done, decisions regarding food and fluids, or decisions regarding medication or mobility." There was no evidence to show staff had considered the person may be capable of making certain choices, such as what meal they would like to eat or what they might prefer to wear. This was an infringement on the person's human rights.
● Staff did not always complete mental capacity assessments and best interest decisions documentation fully and effectively. Assessments also contained inaccurate and contradictory information.
● Mental capacity assessments in one person's care plan contained contradictory and inaccurate

information. In the person's mental capacity assessment staff had written: "[Person] is lacking in capacity and cannot make simple decisions for herself." In the same person's record, another staff member had assessed the person's capacity to make decisions about taking medicines. The staff member had written, "resident was able to accurately point out/pick purpose of...medicines…offered space of 5 mins to recall information given. Used pictures to indicate answer yes/no...resident does have challenges re communicating but does have capacity."

● The same member of staff then completed an assessment to indicate if a decision about medicines should be made in the person's best interests, despite having stated the person did have capacity. Best interest decisions for specific areas of care and support can be made only where it is deemed the person does not have the capacity to make those decisions for themselves. In the section asking if the person had a cognitive impairment the staff member wrote: "yes, even though no concrete evidence of dementia." This information was not relevant to the assessment as the person's cognitive impairment was due to a stroke.

● In the same person's care record staff had written the person's relative, "…makes most decisions". There was no evidence the relative had been authorised to act as the person's legally appointed representative and make decisions on their behalf.

● In another person's record staff had assessed their capacity to take medicines. The section regarding fluctuating capacity stated, "If your resident experiences fluctuating capacity their assessment may need to be repeated...record your reasons for repeating the assessment here." The staff member had written, "[Person] has a DoLS in place." This did not provide a sufficient explanation for why the assessment should be repeated.

● The document also did not stipulate when the assessment should be repeated and stated, "ongoing." This indicated the staff member completing the assessment did not understand fluctuating capacity and had therefore not completed the assessment effectively.

● The above areas placed people at risk of receiving care which was not individualised and did not meet their choices and preferences.

● The local authority supported the service with MCA and DoLS assessment, monitoring and review. However, they stated insufficient improvement was made. They commented, "Our biggest concern continues to be around the extensive lack of understanding and application of the MCA in the home, which of course impacts on all aspects of the service."

The registered person had failed to keep complete and accurate records of consent and decisions made by people or on their behalf in their best interests. This was a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

At the last inspection staff did not always work effectively with other agencies to provide effective support and promote people's health and wellbeing. We made a recommendation about this.

At this inspection we found the service had made improvements.

● People's care and support documents contained evidence of referrals and communication with health care professionals when staff observed changes in people's conditions.

● One person's care plan contained records of conversations between a staff member who was a registered nurse and the person's GP, as well as specialist nurses. Evidence showed medical advice was sought in a timely manner.

● Another person's care plan contained evidence of communications between staff and a specialist nurse, to help manage the person's condition.

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 our last inspection we rated this key question inadequate. At this inspection the rating has changed 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; Working in partnership with others
At the inspection on 5 October 2021, 6 October 2021 and 12 October 2021, there was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because systems or processes were not established and operated effectively by the registered person to ensure to good governance. We issued a warning notice against the provider.

- Some changes to implement an improved governance system and structure were made by the service since the last inspection. Further improvement is required and actions to improve the leadership and governance are not complete.
- There was still no permanent home manager in post. Since the last inspection a series of managers were assigned to maintain day-to-day oversight of the service. This included a manager from another care home, a regional support manager and an interim manager from an external agency.
- In the absence of a permanent home manager, the managing director stated there was a manager or managers present in the service. There was some fragmented responsibility and accountability between the different managers at times.
- The service had committed to employing a registered nurse as the next home manager. They determined that a healthcare professional would be more suitable in the role. The managing director explained the knowledge, skills and experience they sought in the next manager.
- As a condition of registration, the provider is required to register a manager with the CQC. We discussed this with the managing director who clearly understood the requirement. Since the last inspection, several candidates were shortlisted, but not employed because they did not meet requirements to effectively lead the service. Recruitment was ongoing.
- A new clinical lead (deputy manager) had commenced since the last inspection. They were knowledgeable, experienced and skilled in adult social care. They understood their role in the operation of the service. They had not received a probation meeting or supervision with any management team member. We pointed this out so the management could undertake this with the clinical lead.
- Following the enforcement at our last inspection, the provider had created an action plan to record the actions they would take to gain compliance with Regulation 12 and 17. The action plan was detailed, kept updated and reviewed by the regional manager and managing director regularly. Progress was made on most of the actions, with some ongoing and still to be completed. Some actions were marked as complete, but the service had not determined or assessed that the changes made to address issues were sustained over time.

● The provider developed an aide memoire dated February 2022 of meetings, audits and checks that needed to be carried out at the service. The interim home manager showed us which elements were completed and which were missed or not completed. They acknowledged that due to repeated changes in management, not all the tasks set out in the document were completed.
● Staff members carried out medicine audits. However, the audits were not robust and had failed to identify the concerns relating to medicine management we found during our inspection. The management team accepted our feedback; they took action to address the quality of the medicines auditing.
● The local authority worked with the service in an ongoing attempt to improve care and support provided to people. They had already supported the service prior to our last inspection. They kept us informed of their concerns about the service, as they completed their own checks on whether people received safe , effective and well-led care.
● The local authority felt not enough progress was being made, and the service's ability to make and embed improvements were impacted by several factors. They cited the inconsistent management arrangements, poor communication between managers and a lack of productive engagement with the local authority, including the care home support team. The local authority expressed they were not confident about the delivery of safe and effective support to people.

We are satisfied the provider has complied with the warning notice at this inspection. However, the governance of the service still requires further improvement. This is a new breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There was evidence of management meetings, both at local level and regional level. We reviewed the minutes to check how effective oversight from outside the service was. There was evidence that the regional manager was reviewing outstanding actions, and they acknowledged and provided evidence as to why some actions remained overdue.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● A change in the culture of the service was in progress. Further engagement with people, staff and relatives was required to embed a person-centred, inclusive environment.
● People we observed appeared content, although many were not able to speak with us. On the majority of occasions, we observed staff interacting with people in a kind and caring approach. There were a couple of instances where staff did not respond to people in an appropriate way, and we provided this feedback to the staff members when we witnessed it.
● The activities programme continued to be a favourite aspect for people. The activities coordinators were engaged and enthusiastic, and observed attempting to enrich people's lives, as far as possible.
● We spoke with staff who provided positive feedback. One stated, "We had about three managers by now… the leadership was inconsistent. I can see improvements now and there is more continuity in staffing. The clinical lead is making sure the same agency staff comes in (including care staff and nurses). The interim home manager is very supportive; he attends every meeting during the day; he always reassures us that we can come and see him."
● Other staff commented, "The clinical lead is very supportive, even if she is busy, she will always help, like check the wound chart. Daily we are reminded to make sure everything tallies like medicine, records…", "It is good that the clinical lead and the manager are clinical as otherwise it can clash in opinions", "I already see the difference. I am more relaxed now than I was in October [2021], as I felt too stressed, thinking how we would cope!", "Now it is good. We have regular agency staff, even a manager [who] is helpful, talks openly to us" and "Even [the managing director] comes in and asks us how we are, and he comes to our level, it's good, it's positive for us. Because before that, we felt it was up to us to do it all."

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

● Care notes showed that information and support was provided to people and relatives when things went wrong. For instance, if a person's health deteriorated then the family members were informed by staff and this was recorded in the daily notes.

● Since the last inspection, various management team members sent notifications to us pertaining to events where they were legally required to submit the information. A small number of notifications did not have copies of supporting documentation kept at management level. Not all of the notifications were logged in the central electronic system for recording events.

● We examined two serious injury notifications we received. One was submitted by a prior manager without confirming the person's condition first. They reported the person had sustained a fracture, however the person had a cardiac condition treated at hospital. Another person's deteriorating medical condition was reported to us via notification, from a different prior manager. This matter did not require a notification as it was not an injury.

● We found a complaint made by a relative of an allegation of neglect. They had reported their concern to the local authority directly, and the service was aware of the allegation. However, the service failed to send the appropriate notification to us. This was an oversight by a prior manager.

● When we contacted the interim home manager, they were aware of the matter and why it wasn't reported to us. We took this into account and considered that the current management team were reporting all required matters to us using notification forms.

● The regional manager and managing director had a satisfactory understanding of duty of candour. They described candour as being open, honest and transparent with people and relatives.

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

● Meetings were held with people, relatives and staff. Although they weren't held regularly since the last inspection there was evidence of meetings planned for the future.

● Minutes from the meetings showed the provider had provided relevant information about the status of the management, actions being completed and areas that still required improvement.

● People's voice and opinion was captured well within their meeting. There were a small number of feedback points from their meeting minutes, but most of the content captured was what was told to the attendees. The staff meeting minutes contained little evidence that staff were asked for opinions, ideas or suggestions. We pointed this out to the management team who were receptive of our feedback and agreed to modify the format of the meeting minutes to capture more feedback from others.

● There was a weekly 'surgery' (video discussion) with the interim home manager held with relatives. This was an opportunity for them to seek advice, raise issues and be provided with updates. An e-mail summary was sent out after the meeting, so those who did not attend received updates.

● Surveys of people, relatives and staff had not occurred since the last inspection. There was a plan to conduct them and gather feedback.

Continuous learning and improving care

● The service held daily meetings between the heads of department, clinical lead and interim home manager to discuss people's needs and tasks for the day. This was an effective method of reviewing outstanding tasks and items that required immediate attention.

● One staff member said, "During [these] meetings we get to discuss incidents and accidents or any other issues; what to do and how to solve issues. We always talk about safeguarding cases, what to do next and we are always kept in the loop."

● We checked examples of the daily meetings where actions were required. We found they were completed,

and the deputy manager was good at ensuring nursing and care staff had followed through with actions assigned to them.

● We suggested to the management team that the previous days' meeting notes should be reviewed the next day, in case any actions were still outstanding. They accepted this finding and stated they would change the process to prevent any actions being missed.

● There was no process in place to receive and act on medicines alerts. We informed the management team so they could take action to ensure medicines and equipment alerts (if applicable to the service) were reviewed and acted on.

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
Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent How the regulation was not being met: The registered person had failed to keep complete and accurate records of consent and decisions made by people or on their behalf in their best interests.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met: The registered person did not ensure that the premises used by the service provider were safe to use for their intended purpose and are used in a safe way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment How the regulation was not being met: The registered person had failed to ensure the premises were suitable for the purpose for which they were being used in relation to their suitability for people living with dementia.

Regulated activity	Regulation

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance How the regulation was not being met: The registered person had not established an effective system to enable them to ensure compliance with their legal obligations and the regulations.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed How the regulation was not being met: The registered person had not ensured recruitment procedures were established and operated effectively to ensure only suitable staff were employed.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing How the regulation was not being met: The registered person had not ensured staff were suitably qualified, competent, skilled and experienced to carry out their roles effectively.