Ealing Eventide Homes Limited

Ealing Eventide Homes Limited - Downhurst

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
Is the service effective?	**Good**
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
Ealing Eventide Homes Limited – Downhurst is a care home for up to 26 older people. At the time of our inspection, 18 people were living at the service. Some people were living with the experience of dementia. The service is managed by Ealing Eventide Homes Limited, a charitable organisation. This is their only registered care home.

People's experience of using this service and what we found
Since the last inspection the provider had made some improvement to the management of risks but we found there were still risks which had not been assessed, monitored or managed in relation to people's health and wellbeing. Medicines were not always administered as prescribed and records did not always reflect the medicines received by people.

The provider had made some improvement to care plans, but they still did not always provide information on people's current care and support needs. There were therefore risks that people might not receive the care and support they needed. There had been some improvements in the quality assurance processes the provider had in place, but further improvements were required to ensure these were robust and effective so that areas for improvement were identified and addressed.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. We identified that mental capacity assessments had not always been completed, where required, in relation to vaccinations. We made a recommendation in relation to mental capacity assessments.

The provider had made some improvements to activities which were provided in the home but further actions were required. We have made a recommendation to the provider in relation to the provision of activities.

Despite the above people and their relatives felt care was provided in a safe manner. The provider had a robust recruitment process. Relatives were happy about the care their family members received and they felt the care workers were kind and caring. People's support needs were assessed before they moved into the home to ensure their care needs could be met. People were supported to access healthcare professionals when required to promote a healthy lifestyle. Care plans and risk assessments were updated with the lessons learned following an incident and accident, but the lessons learned and how these had been shared with staff had not always been recorded to demonstrate there had been wider learning. The registered manager confirmed they would ensure the records were always completed in full.

Care workers completed a range of training courses and they felt supported in their role. Care plans identified people's food and drink preferences with any dietary requirements. People's religious preferences

were identified, and these were supported with visits from the local faith community. The provider had a complaints process in place that people and their relatives were aware of. Relatives felt the home was well run and the registered manager was effective.

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 5 July 2022). 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 remained in breach of regulations. This service has been rated inadequate for the past two inspections.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection. We have found evidence that the provider needs to make improvements. Please see the safe, responsive and well led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Ealing Eventide Homes Limited – Downhurst on our website at www.cqc.org.uk.

Enforcement and Recommendations
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 breaches of regulations in relation to person-centred care, safe care and treatment and good governance at this inspection.

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

Follow up
The overall rating for this service is 'Requires improvement'. However, we are placing the service in 'special measures'. We do this when services have been rated as 'Inadequate' in any Key Question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.
If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.
For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Ealing Eventide Homes Limited - Downhurst

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was conducted by two inspectors, and a medicines specialist advisor. An Expert by Experience supported the inspection by contacting the relatives (and friends) of people who used the service after our visit. 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
Ealing Eventide Homes Limited – Downhurst 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. Ealing Eventide Homes Limited – Downhurst is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the

quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
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 used all this information to plan our inspection.

During the inspection
We spoke with 5 people who used the service and 8 relatives. We also spoke with 7 staff members which included the registered manager, deputy manager, nominated individual, a house keeper and 4 care workers We reviewed a range of records which included 7 people's care plans, various medicines records and the recruitment records for 1 new care worker and supervision records for 4 staff members. After the visit to the service we continued to seek clarification from the provider to validate the evidence we reviewed.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection the provider did not ensure that risks were identified, monitored and mitigated. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

• At the inspection in April 2022 we saw the provider had made improvements to the risk management system but had not fully implemented the system to ensure risks to people were always appropriately identified so these could be mitigated.
• We found that risks associated to a person's health and wellbeing had not always been identified and therefore a risk management plan was not always in place as part of a person's care plan. For example, we found that there were no risk management plans where people had medical conditions relating to dry skin, breathing issues and a problem with the digestive system. There was no information provided on these medical conditions which people lived with and how the care workers should support each person.
• The best interest decision for one person identified they were at risk of choking, but a risk assessment and risk management plan had not been developed to provide care workers with guidance on how to support the person when eating and drinking to reduce the risk of choking.
• The care plan of another person indicated they needed to be repositioned regularly to help reduce the risk of developing pressure ulcers. However, the care plan did not give a frequency for repositioning when in bed or in a chair. Guidance was given on how to reposition the person in their chair, but the record of care completed by care workers did not always indicate when the person was repositioned, which side the person was repositioned to and it was not always clear if the person was in bed or seated in a specialist reclining chair when repositioned. This meant it was not clear if the person had been repositioned appropriately to reduce the risk of skin integrity issues.

We found no evidence that people had been harmed. However, the provider had not ensured that risks were always identified, monitored and mitigated. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People had risk assessments and risk management plans which had been completed for a range of issues which included falls, mobility, moving and handling and the risk of the person developing pressure sores.
• Risk assessments were also completed in relation to people who were able to access the stairs without the need of support from care workers. There were additional risk assessments if the person was unable to use

the call bell and if bed rails were in place to reduce the risk of falls from bed.
• Risk assessments were also developed for medical conditions such as dementia, catheter care and diabetes.
• Personal emergency evacuation plans (PEEPs) were in place which provided information on how people should be supported if they needed to be evacuated from the home in case of an emergency.
• At the April 2022 inspection we identified a risk assessment for one person had not considered all the risks related to the stairs located near to their bedroom. At this inspection we found a gate had been installed to reduce access to the stairwell and the stairs risk assessment had included all the possible risks with accessing the stairs and how these could be mitigated.
• The registered manager explained they had developed a risk assessment which included infection control and general safety for visitors from external groups such as school and religious groups who provided entertainment.

Using medicines safely

At our last inspection the provider did not ensure people's medicines were always administered as prescribed. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvements have been made and the provider was still in breach of regulation 12.

• At the inspection in April 2022 we found the provider had not made enough improvements to the way medicines were managed to ensure people always received them as prescribed. During this inspection we again identified concerns in relation to the administration and recording of medicines. This meant people were at continued risk of not receiving their medicines as prescribed.
• The medicines administration record (MAR) for one person indicated they had prescribed medicines which needed to be administered at specific times. The administration times recorded on the MAR for the medicines cycle starting 17 October 2022 were not the same as those indicated on the previous month's medicines cycle. This change had not been identified when the MAR had been delivered to ensure they were accurate. During this inspection the registered manager confirmed the MAR had been updated to reflect the prescribed times.
• The provider did not have an assessment system for pain in place, such as the Abbey Pain Assessment Tool or an equivalent for care workers to use to monitor people's pain levels in circumstances where they were unable to verbalise their pain levels such as if they were living with dementia. This would have enabled the care worker to identify when the person was in pain and therefore required their pain relief and how much to give in cases where a variable dose of the medicine as prescribed.
• The provider had not developed risk assessments for the use of emollient creams which contained products that made the cream flammable, for example liquid paraffin. We identified three people had been prescribed creams which contained liquid paraffin. This meant care workers were not provided with guidance on how to reduce the risks associated with paraffin when these creams were being administered.
• The MAR for one person indicated they had been prescribed an inhaler to be administered twice day. The MAR chart for the month from the 19 September 2022 showed that it had only been administered once a day. The MAR included directions for administration which stated it should be administered twice a day. This meant the person did not receive their medicine as prescribed.
• When one person had been discharged from hospital, they had been prescribed an oral nutritional supplement drink to be administered twice a day for eight days. The prescribed supplement had been added to the MAR by hand and had not been checked by two care workers in line with medicines management guidance to ensure the record was accurate. The MAR showed it had been administered twice on one day and then once a day for the remaining 15 days. The MAR did not indicate why the supplement

drink had been administered in this way. This meant it has not been administered as prescribed.
• One person was diabetic and required insulin which was administered by the district nurse who visited the home twice a day. The MAR showed the senior care worker on duty had initialled the MAR which indicated they had administered the insulin when they had not. Therefore, the MAR did not accurately reflect how this medicine was being administered.
• The care plan for this person stated that care workers should check the person's blood sugar levels if required and offer fizzy drinks if needed but there was no guidance on what the acceptable sugar level for this person was to ensure appropriate action was taken if needed. The person had been prescribed a dextrose gel to be used to provide a sugar boost when required but this was not mentioned in the care plan as an option and there was no instruction on the blood sugar level reading which would require the dextrose gel to be given.
• The registered manager confirmed that care workers had not received training on how to check blood sugar levels and how to calibrate the testing equipment to ensure the results were accurate. This meant that there was a risk that the person's blood sugar levels might not have been appropriately monitored
• The MAR for another person indicated they had been prescribed anticoagulants, but a risk management plan or extended care plan had not been developed to provide care workers with guidance on the possible impact these medicines may have had on how care was provided and how they could support the person.

We found no evidence that people had been harmed. However, the provider had not ensured that people were always protected against the risks associated with medicines. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Following the inspection the registered manager confirmed the person's care plan had been updated with additional information including the acceptable blood sugar levels and the use of prescribed dextrose gel.
• We reviewed a sample of medicines which had been provided in their original packaging and in a monitored dosage system. We found the amounts of medicines in stock matched the amounts of the medicines the senior care workers recorded through their daily stock counts.
• Where a person had been prescribed a medicine to be administered as and when required (PRN) the provider had ensured a protocol was in place which indicated when the medicine should be administered. The PRN protocols had been signed by the staff member who created them, and the date of review was recorded. In the majority of PRN records, we saw senior care workers had recorded the reason for administering the medicine and the dosage.
• The provider had a process for managing controlled drugs and we saw that when controlled drugs had been returned to the pharmacy the appropriate records had been completed.
• The temperature of the medicines room and the fridge used to store medicines was regularly checked, recorded and were within acceptable targets to ensure medicines were stored at the correct temperature.
• The medicines room was tidy and well ordered, the medicines fridge was clean and was not overstocked. When medicines were returned to the pharmacy for destruction the appropriate paperwork had been completed.
• The provider had developed medicines risk assessments for people who had been prescribed medicines. The medicine risk assessment included information of each medicine prescribed, how and when it should be administered and any side effects.

Learning lessons when things go wrong

At our last inspection the provider had not ensured that lessons learned were always identified and care plans and risk assessments were updated to reflect when things went wrong. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made and the provider was no longer in breach of regulation 12 in relation to identifying lessons learned.

• The provider had a process for recording incidents and accidents and care plans were updated to reflect any changes to the person's care from the lessons learned.
• We saw from the five incidents and accidents and two safeguarding records we reviewed, each person's care plan and risk assessment had been updated to reflect what had happened. For example, where a person had experienced a fall, we found their care plan included information on the fall with any additional equipment to be used to reduce the risk of further falls and the falls risk assessment had also been updated.
• We saw that all the lessons learned following an incident and accident and how these have been shared with staff had not been recorded to demonstrate there had been wider learning but the care plans had been updated. We discussed this with the registered manager, and they confirmed they would ensure the records were completed in full.

Systems and processes to safeguard people from the risk of abuse
• The provider had a process for the reporting and investigation of safeguarding concerns. The registered manager had ensured a referral form had been completed and sent to the local authority safeguarding team when a possible safeguarding issue had been identified. We reviewed the records of two safeguarding concerns which contained information on the issue, what action was taken to reduce further risks and the outcome of the safeguarding investigation.
• Care workers we spoke with confirmed they had completed training on safeguarding adults. They demonstrated a clear understanding of the principles of safeguarding and how it impacted on their role and how they provided care.
• Relatives told us they felt their family member was safe receiving care and living at the home. They said "I think she is extremely safe, if [my family member] was at her own home, I don't think she would be as confident. The quality of care is so good and she gets her medication and her food" and "Yes, I think so, I get a sense she is safe; She has been there a long time, it does not seem an unsafe place to me when I visit."

Staffing and recruitment
• The provider had a robust recruitment procedure which meant they had checks in place to ensure new staff had the required skills for the role.
• We reviewed the recruitment records for one new staff member who had been recruited following the previous inspection in April 2022. The provider had received a range of checks including two employment references, evidence of the applicants right to work in the UK and a Disclosure and Barring check. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
• The registered manager explained a dependency assessment was completed for each person which identified the level of care they required and how many care workers were required to provide that care.
• The registered manager told us there was one senior care worker and two care workers on duty during the day with additional support from the deputy manager and the registered manager. At night there was one senior care worker and two care workers on duty. We did observe there were times during the day when care workers were sometimes stretched when providing care for example during lunch. The registered manager confirmed they and the deputy manager were actively involved in providing support when required.

Preventing and controlling infection
• We found the home was clean, tidy and free from any malodours as regular cleaning was carried out.
• We saw staff members wore personal protective equipment (PPE) in line with guidance which was in place at the time of the inspection. There were clinical waste bins located in bathrooms so staff could dispose of PPE appropriately.

• Training records demonstrated that staff had completed infection control training which included the use of PPE and training on COVID-19.
• COVID-19 risk assessments were in place for people living at the home and for staff members. These identified if the person or the staff member had any risk factors such as their gender, ethnicity or pre-existing medical conditions which increased their possible risks from COVID-19.
• Visitors were supported to comply with current COVID-19 guidance for care home visiting and provided access to masks when required.

Good

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 requires improvement. At this inspection the rating has changed to good. This meant people's outcomes were consistently good, and people's feedback confirmed this.

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 our last inspection the provider did not always ensure people were supported to make decisions about their care in line with the principles of the MCA. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We issued a Warning Notice to the provider requiring them to comply with the regulation by 1 August 2022.

The provider had made improvements to meet the regulation, but we have recommended that further consolidation and implementation of good practice be made to ensure the principles of the MCA were always followed.

• The provider had introduced processes to ensure care was provided within the principles of the MCA and in the least restrictive way possible.
• The registered manager had completed mental capacity assessments and best interest decisions for people to identify if they could consent to specific aspects of their care which included the administration of medicines, the use of bed rails and personal care.
• Mental capacity assessments and best interest decisions had also been carried out for the use of bedroom door sensors and keypad-controlled doors which were in place to reduce the risk of a person falling if they accessed the stairs without support.
• However, we identified mental capacity assessments and best interest decision were not always

completed for people who did not have capacity to consent to a COVID-19 booster vaccination. We reviewed the forms for the administration of the COVID-19 booster which obtained the consent of relatives of people who do not have the capacity to consent to the vaccination, with no evidence that they had a Lasting Power of Attorney. We saw, where the person did not have a Lasting Power of Attorney for health and wellbeing in place, the registered manager had not completed a mental capacity assessment and the administration of the vaccination was not recorded as being in the person's best interest.

We recommend the provider review current and improve practice to ensure the implementation of the principles of the MCA in relation to supporting people to make decisions.

• We discussed this with the registered manager, and they confirmed they would ensure the mental capacity assessments will be completed with best interest decisions for the flu vaccinations.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's care and support needs were identified before the person moved into the home to ensure they could be met. A care needs assessment was completed, and the information was used to develop the person's care plan and risk assessments.

Staff support: induction, training, skills and experience
• Care workers received the support and training they required for their role.
• The training records for staff demonstrated most staff had completed the training courses which were identified as mandatory by the provider. The mandatory training courses completed included dementia awareness, equality and diversity, fire awareness and health and safety. The registered manager told us they had booked additional training courses which included training on Parkinson's disease and an advanced training course for the administration of medicines for senior staff and senior care workers.
• The staff records for one new care worker who had been recruited since the last inspection showed they had completed an induction and shadowed experienced care workers. Records we reviewed showed care workers had regular supervision meetings and an annual appraisal.
• Relatives said they felt the staff had completed the training they needed to provide appropriate care. Their comments included, "Well they all were taking qualifications and updating them. They all seem to come across as knowing what they are doing" and "Yes I suppose if they were not trained, I would notice. [I have] never seen any staff who don't appear to know what they are doing."

Supporting people to eat and drink enough to maintain a balanced diet
• People were provided with food and drink of their choice as well as ensuring their dietary needs were met.
• Care plans included information on people's food and drink preferences. We saw people were supported to choose the food they ate for lunch.
• The kitchen staff had information on every person with specific dietary needs which included if the person was diabetic, needed fortified food or required a soft or pureed diet.
• Relatives confirmed their family members enjoyed the food provided, "Yes there is always a menu up on the wall and it looks varied. [My family member] eats very well so that a good sign. Yes, they definitely go around with a tea trolley and extra drinks every day" and "I think it's really good, the menu changes every day and there seems to be a variety. Yes, they get enough, and the staff encourage them and feed them."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• People were supported to access healthcare and other services if there was a change to their care needs and to enable them to live a healthier life. One person told us the staff supported them to order new hearing aids.

• The registered manager confirmed the home had recently moved to a new GP practice and the practice nurse visited the home every week to see people who had been identified as requiring a visit.
• Relatives we spoke with confirmed their family members had access to healthcare services. Their comments included, "Yes, [person] gets podiatry done, the dentist we sort out but they sort out all other appointments and they will always let us know" and "They have just joined with new GP surgery and they have a round system. They have opticians and dentist appointments and the home organises all that."

Adapting service, design, decoration to meet people's needs
• The provider had ensured the environment of the home was safe and met the needs of people including those living with dementia.
• The improvements which had been made prior to the April 2022 inspection had been maintained. The environment supported people to be as independent as possible with corridors and communal areas having enough room to enable people to move around without support or if required to use mobility equipment.
• People were able to see the garden and were supported to access the garden weather permitting. One person said, "What I love most here is the garden and the plants and flowers. I sit in the chair in the corridor and look out the window."
• An area with armchairs had been created away from the main lounge to enable people to have a quiet area to sit or to meet with relatives and visitors.
• People's bedrooms had been personalised and pictures of parties and events which had been held in the home were displayed in communal areas.

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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed to 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; Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence

• People told us they felt the care workers were kind and caring and their comments included, "If I need anything staff are very good. If don't feel well in the night staff are there to look after you" and "On the whole staff are nice."
• Relatives we spoke with confirmed they felt care workers were kind and caring to their family member when they provided support. They told us, "They are friendly and warm, helpful and polite and I have a good relationship with them; they always take an interest", "They are dedicated, caring and people focus; they update stuff on an iPad. When I visit, I can ask any one anything and they will have an answer; they are caring for sure" and "I say friendly, kind and welcoming when we go to the home. The staff have been there a long time so they are vocational and they really care."
• We observed care workers provided support in a kind and caring manner and understood the needs of people which supported the feedback received from people living at the home and relatives.
• Relatives felt the care workers ensured their family members dignity was maintained and support was provided in a respectful way. Relatives said, "100% yes, from what I have observed and my [family member] would be the first to tell me if it wasn't", "Yes definitely from what I see [my family member] puts their head down a lot and they always take time to bend down and speak to my [family member]. They are always kind and respectful" and "Absolutely, always treat every person with dignity and respect."
• Relatives confirmed they felt the care workers supported their family member to maintain their independence. They said, "Yes, so the whole thing with [person's] walker, it would be easier to just put them in the wheelchair but they encourage [person] to use the walker" and "Yes, [person] is independent, they walk with a stick and has stopped using a frame. That's the proof of the pudding."
• People were asked by care workers if they needed or wanted anything. Relatives told us they felt the care workers involved their family member and asked them what they wanted. Their comments included, "Yes they do and also with me, they are good at noticing things and they do have a chat with [person]", "Yes, they always ask questions, but because of the level of [person's] condition they don't really get much responses, but they always ask", and "They will speak and treat [person] in a way that they should be spoken to. They are really good with the residents".
• People's religious and cultural preferences were identified, and they were supported. The care plans identified people's religious wishes and the registered manager confirmed members of the local faith

community regularly visited the home. This was confirmed by relatives we spoke with. One relative commenting, "So yes, I think they would respect that. I know they have someone came in on a Sunday and they have a little service and [our family member] attends that, but [our family member] does not have anything specific. The vicar sometimes come to see them and sometimes church members visit."

• Relatives we spoke with told us their family member had been involved in the development of their care plan. Other relatives confirmed that as their family member was unable to make decisions about their care they were involved in the development and review of their care plan. Their comments included, "When [family member] was first there they did [involve them], but now they involve us much more as [family member's] condition has deteriorated. They have always kept us informed and I have never had any concerns. They will ring me and involve me if they need to ask for [family member], I trust them as I have never seen anything to make me doubt the standard of care" and "Yes my [family member] was involved and also myself and my wife with the manager and senior staff. I am not sure how often the care plan is discussed, but we talk about [our family member's] care with managers."

• Relatives confirmed they were kept informed about their family members and the care their received. One relative said, "Yes, because I think they are very attentive and they consider residents as people, so they are able to have a bit of a life. They just really care. We have regular updates and they are very helpful and can tell me about what [my family member] does, they take an interest in [person]."

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question requires improvement. The rating for this key question has remained 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

At our last inspection the provider had not always ensured the care being provided was person-centred. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some improvements had been made but further action was required and the provider was still in breach of regulation 9.

• At the previous inspection in April 2022 we found care plans did not always reflect the person's care needs and the wishes of the person in relation to how they wanted their care provided. During this inspection we found not enough improvements have been made a there were still care plans which did not reflect people's support needs.
• The care plan for one person indicated the person no longer had teeth and could not wear dentures or use mouthwash. The personal care section of the care plan stated they did not have any oral care which meant there was no information for care workers on how they could support the person to maintain good oral healthcare.
• People were not given a choice of the gender of care worker who provided their personal care. This meant by not identifying the person's preference care workers could not be allocated accordingly to ensure the person felt comfortable with the care worker providing their personal care support.
• The care plan for one person had not been updated to reflect their new care needs following discharge from hospital. We saw the guidance was given in the discharge summary on how the person should be supported once they returned to the home, but this had not been included in the care plan or risk assessments. We also saw notes on a separate file from an assessment carried by an Occupational Therapist indicating exercises the person should be supported with and guidance that they should sit in a chair for no longer than one hour, but this information had not been included in the care plan or risk assessment. This meant care workers had not been provided with information on the changes to the person's care to ensure their care was provided in a person-centred way.
• The falls risk assessment and the mobility section of the care plan for one person indicated that they used a walking frame around the home, but we observed during the inspection this person did not use a frame and was walking independently. This meant the care plan and risk assessment had not been updated to reflect the person's current mobility support needs.
• The care plan for one person indicated they were at risk on malnutrition and required supervision and encouragement when eating. We observed lunch on the first day of the inspection and we saw this person was given their lunch and we did not see that they were supported appropriately to eat their meal. Other

people sat at the same table tried to encourage the person to eat their lunch, but the person became frustrated and did not eat the meal. After 20 minutes a care worker took the plate away and gave them pudding which they ate and a supplement milkshake. Our observations confirmed that the person's care plan around the support they needed at mealtimes, was not appropriately implemented so the person could maintain their levels of nutrition.

The provider had not always ensured care plans included information which recorded the person's current care needs and the preferences of the person and that these were appropriately implemented. This was a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities).

• The registered manager had now fully implemented the electronic care planning system. The information from the paper-based care plans had been transferred to the computer-based system and this could be accessed by care workers from mobile handheld devices. Care workers could also record the care they had provided using the handheld device.
• Notwithstanding the issues identified above we found that the care plans for other people included information on their care needs and their preferences as to how their care should be provided.

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

At our last inspection we recommended the provider seek and implement national guidance on the provision of social and recreations activities for older people in care settings. The provider had made some improvements, but further action was required.

• Some people felt there were not enough organised activities to engage in. People we spoke with said, "We don't have enough activities going on, that's the bad bit. Just sitting in the lounge looking at rubbish television. If it is a nice weather day, we have the advantage of we can walk around the garden" and "Less activities since I came to live here."
• We saw that care workers were trying to organise activities, but these were not always planned or structured. We observed a care worker going from person to person in the lounge asking if each person wanted to paint or read a book, but people were not always given time to make a choice or to understand the options. We saw one person was asleep and a care worker placed an activity in front of the person asking if they wanted to play but the person was clearly asleep. We saw some activities were carried out such as a bean bag game but there was no indication that the activities were meaningful for each person or what they were interested in. What activities people took part in were not always recorded so the information could be used to evaluate how the care plan was being implemented.
• We saw there were pictures of parties and events which had been organised and there were also posters for an entertainer who visited the home once a month.
• The registered manager told us they were in the process of recruiting a new activity coordinator and were working towards having a structured activity schedule which reflected people's interests and was meaningful.

We recommend the provider seek and implement national guidance on the provision of social and recreations activities for older people in care settings.

• The registered manager explained they had introduced a new sensory room which staff supported people to use. One care worker told us, "The sensory room is working well. [Person's name] who has behaviour that challenges, sometimes I take them there for 15 to 20 minutes and they are happy." Two relatives confirmed their family members regularly used the sensory room and they appeared to enjoy it as it was a calm,

relaxing environment. The provider had also recently introduced an interactive touchscreen table which will enable people to play games and listen to music and audio books.

End of life care and support
• People's end of life care wishes were identified and addressed in the care records.
• The care plans had a section which identified how people wanted their care provided as they reach the end of their life which included if the person wanted to stay at home if their health deteriorated, if they wanted to be visited by a representative of their faith community, who they wanted informed and if they had a funeral plan in place. This meant staff had the necessary information to support a person should they develop end of life care needs

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

• People's care plans included information on their communication needs. There was a specific section of the care plan for communication which included information on the person's preferred language and if they could express their wishes and preferences verbally.
• Care plans also indicated if the person verbally expressed themselves, but their words could become confused and how the care workers could support them for example give the person time to respond.
• Care workers were also provided with guidance on how to reassure, support and comfort people if they were having a bad day or if they became frustrated.

Improving care quality in response to complaints or concerns
• The provider had a procedure for investigating and responding to complaints. We reviewed the records for two complaints that were received since the last inspection. The records indicated that complaints had been investigated with the outcome reviewed and actions had been taken to resolve the issue.
• Relatives confirmed they knew how to raise any concerns or complaints. One relative commented, "Oh yes I would make a complaint on [family member's] behalf, if there was one. I would expect something to be done about it, but there has never been the need to make a complaint."

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

At our last inspection we identified there were a number of continued shortfalls which meant the provider had not developed effective quality assurance and governance processes to assess, monitor and improve the quality of the service to ensure people always receive high quality and safe care. This was a continued breach of regulation 17 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.

• The provider had made some improvements to the management of risks, but we identified shortfalls with the provider's arrangements and systems to manage risks. This was because risks were still not always being identified and risk management plans developed where indicated. We found that risks management plans had not been developed for some medical conditions and for choking. The monthly managers self-audit had not identified the shortfalls with the current systems around the management of risks.
• The registered manager confirmed they carried out a weekly medicines audit, but we found the audits had not been effective as they had not identified the issues we found during the inspection. Therefore, the medicines audits had not always identified the shortfalls we found around the management of medicines which meant appropriate action could not have been taken to resolve the issues.
• At the last inspection in April 2022 we identified the registered manager and deputy manager had carried out medicines competency assessments for senior care workers but could not demonstrate they were up to date with current best practice. The registered manager confirmed they would organise additional training for medicines. At the October 2022 inspection the registered manager confirmed they had their competency assessment to administer medicines carried out by the improvement consultant who is a nurse. The registered manager explained they had booked places for senior staff on an advanced medicines administration course, but they had not yet completed it. We found the registered manager had carried out medicines competency assessment for the deputy manager who then assessed the competency of senior care workers before they had completed the advanced training course to provide them with an update on current best practice.
• The provider did not always ensure a contemporaneous and accurate record of the care provided to each

person was completed to reflect the care staff delivered. We saw there were gaps in the recording which meant there was not always information about whether the person had received safe and appropriate care. For example, the records of care for one person, who required repositioning every four hours, were not completed as required to indicate they were being repositioned according to their care plan. There was also no record of the person receiving their lunch or any drinks, any personal care, or interaction with care workers during this period. This meant the provider could not demonstrate the care the person received was according to their individual care plan.
• The monthly care plan reviews carried out by the registered manager did not always enable them to identify where information required updating following a change in a person's care needs or where information was missing. This was evidenced by the issues we found in relation to care plans which had not been identified through the monthly reviews.

There were a range of ongoing issues identified at this inspection which meant the provider still needed to ensure the quality assurance processes they had introduced were robust and effective enough to assess, monitor and improve the quality of the service to ensure people always receive high quality and safe care. This was a repeated breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities).

• The registered manager carried out a range of quality assurance audits. This included a monthly management trends analysis report which provided an overview of the recording of dependency levels, falls, infections, the number of people requiring specific nutritional support, staffing and training and complaints and compliments.
• A detailed analysis of incidents and accidents was completed each month which included trends analysis based upon times of day when the fall occurred and the person's falls history. Other monthly audits included a check of slings and hoists and an internal and external environment audit. There were also audits covering health and safety, infection control and one assessing people's dining experience.
• We identified that the daily checks on air mattresses were not always recorded on the electronic care system. We raised this with the registered manager who confirmed care workers carried out the daily checks, but they were not always recording the outcome. They agreed they would review this and discuss it with the care workers. We found a monthly check was carried out to ensure the mattresses were not soiled or damaged.
• The provider is a charitable organisation which is managed by a board of trustees. There were 4 trustees, a chief executive officer, registered manager and deputy manager. The chief executive officer was also the nominated individual for the service. There were clear responsibilities and there were job descriptions for each role.
• The registered manager explained they had employed two improvement consultants to provide support with the implementation of an action plan for improvement. One of the improvement consultants completed a monthly quality assurance audit to monitor improvements at the home.
• Relatives we spoke with gave positive feedback in relation to the registered manager and senior staff at the home. Their comments included, "Well I like [registered manager]; she seems to want to improve the service and seem to be working hard to fix any problems there; she wants to improve the home. I get a positive feeling when I speak to her and she seem to be working very hard", "I think [registered manager] is very good and dedicated, very professional. The seniors are aware of what's going on and very good as well" and "So the manager I really rate; if you had asked four years ago, I would not have said the same thing; I have confidence in her and the senior staff, deputy manager, is lovely and I know her quite well, I am happy."
• The registered manager explained they worked in partnership with a range of organisations which included a local college, religious representatives and community groups.
• The home had changed to a new GP practice and the nurse visited the home once a week to review people which had been identified as requiring a review. The registered manager confirmed the visit by the nurse to each person had not always been recorded. During the inspection the registered manager contacted the GP

practice and arranged for copies of all the consultation records to be provided so people's care plans could be updated. The practice nurse agreed consultation records for future visits would be provided.
• People's religious and cultural preferences were identified as part of the initial needs' assessment of people. The registered manager explained that the service took account of people's diverse needs and people were supported to attend religious services and religious and cultural events were celebrated within the service.
• The provider supported people and their relatives to provide feedback about the quality of the care people received at the home. Annual surveys were carried out with people living at the home, relatives and staff. We saw the results of the recent relatives' survey with positive feedback. A survey had been carried out with people living at the home at the start of October 2022 and the registered manager was in the process of reviewing the results. A survey had been carried out with staff earlier in the year and they gave positive feedback.
• The registered manager explained that they encouraged people who lived at the home to attend the relatives' meetings, so they discuss and feedback on the care. Relatives could also attend the meetings online and the minutes for the meeting were circulated. The registered manager also confirmed that regular emails were sent to relatives to provide updates. When asked about relatives' meetings, relatives comments included, "Yes, they invite everyone, even online too. They seem to take all suggestions on board too" and "Oh yes regularly, and if you can't get in, you can join on zoom; It's attended by some residents and they are actively asked for ideas of what your relatives might need; it's something that's always been in place before and after the pandemic."
• Staff told us they felt supported and they felt the home was well led. Their comments included, "Always I can go to the manager and she will help me. They are always helpful. She always listens. I think the service is improving all the time. I think the new management is doing well", "Have gone to the registered manager a few times but no big issues. Usually go to the deputy manager first. The registered manager is quite accommodating. Good place to work. It gets a bit hectic, but I am surrounded by a lot of good carers and have been here for a long time" and "The management is okay. The registered manager is working hard. For me it is a good service for the people. They are happy here. I try to help them as much as possible. I like to work here. It is hard but at the end of the day I can leave satisfied with my job and helping people in need."
• There were regular staff meetings and notes were taken so staff who were able to attend knew what was discussed. There was a handover at the start of each shift to identify any issues which had occurred or if there was information that needed to be passed on, but these were not recorded. We discussed this with the registered manager who explained that any urgent or important information was written in the communication book so staff could see it, but she would be looking into how the discussions at the handover could be recorded.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• People living at the home said they were happy with the care they received at the home. We also spoke with relatives who told us they were happy with the care their family member received. Their comments included, "Yes I am, when I visit the staff are cheerful and helpful, [my family member] has been there for years and I think the care is fine. [Person] is not needy and they give them the support they need, and now they have activities starting again, I am happy", "Absolutely 100% happy, because of COVID-19 things went a bit askew, but I am completely happy with the care [person] gets, I have been absolutely happy and [person] recognises the staff more than they recognise me" and "I am yes, they always seem to be tender with [person]. [My family member] can be quite demanding and they [staff] remain polite and are kind to her. They make an effort to make life interesting; the carers read to residents".
• Relatives also told us they felt welcomed by staff when they visited the home. They said, "Absolutely, 100%, we can turn up any time and have never been refused entry" and "Yes they are smiley, I know quite a lot of them as [person] has been there a while, I know the lady in the laundry; they are welcoming and polite."

• Relatives confirmed they were involved in the development and reviews of their family member's care plans.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
• The registered manager understood the importance of the duty of candour in relation to their role. They commented, "Being open, honest and transparent. Letting people know what is going on and where we are going and if something happens let the families know and don't try to cover it up."
• The provider's complaints policy clearly indicated the process for the investigation and review of any complaints received. We saw complaints had been responded to in line with the policy. One relative told us, "I imagine if [my family member] had a complaint they would speak to me. It would depend what it was, and I would contact the manager if I thought there was substance to it. I have a good relationship with the manager there."
• Relatives told us that when they contacted the home with a question or concern the registered manager responded in a timely manner. One relative said, "The registered manager is really good, competent and caring. All the residents know her; she's very approachable and always respond to emails."
• A range of policies and procedures had been developed by the provider which were regularly reviewed to ensure they reflected current best practice and legislation.