Teignbridge House Care Home Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Teignbridge House Care Home Limited (Teignbridge House hereafter) is a residential care home providing personal care to up to 24 people, which includes people on intermediate care stays. At the time of our inspection there were 20 people using the service.

People's experience of using this service and what we found
Concerns about the management and monitoring of risk had been identified at our last 2 inspections; at this inspection they were still not being well managed. Risks relating to pressure area care, monitoring of bowels and weight were not always effectively monitored. People's food and fluid intake wasn't adequately monitored, and staff didn't always have enough information about how to manage people's individual health risks. Staff communicated information about people's health at daily handovers, however, because the information wasn't written down there was a risk issues identified wouldn't be followed up. Systems were not always effectively operated to ensure safeguarding was well managed and potential safeguarding concerns were identified.

Whilst some improvements had been made in relation to staff training, not all staff had completed the training required by the service and where they had, care was not always being provided in line with the law or best practice guidance. Only 4 staff had completed dementia training, despite several people at the service living with dementia. No one to one staff supervision had taken place.

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

Care plans did not always reflect people's needs and personal preferences and some contained inconsistencies and errors. For some people, this meant there was incorrect information about how staff should assist them. Care plans were not always regularly reviewed to ensure they met people's current needs.

Following our last inspection, the registered manager, who is also the provider, took the decision to step back from their role. At the time of this inspection, they had not applied to deregister with CQC which meant they were still legally responsible. Quality performance, risks and regulatory requirements were not well managed. There were no systems in place to ensure senior staff and managers had oversight of daily monitoring documents. Whilst audit systems were in place, they had not identified all the areas of concern identified at this inspection, audit tools were not always comprehensive enough to identify risk and where audit systems had identified areas for improvement, action had not always been taken to address the shortfalls identified.

Improvements had been made to the environment, including the management of infection control and fire

safety. New equipment had been purchased and we received positive feedback from health professionals who felt people's health needs were well managed. People told us they felt safe. One person said, "I love it here, I feel safe." People's families told us they also felt people were safe. One relative said they felt their relative was "very safe" and told us, "I don't have to worry about Mum."

People were supported to maintain a balanced diet and their care records contained information about their likes, dislikes, and personal preferences. People were supported to access healthcare services and support, and we received positive feedback from health professionals. One said, "I've provided them with some extra support, and they give me good detail (about people's needs) over the telephone." Another health professional said, "I have full confidence that any health needs will be reported, and any plans I suggest will be actioned."

People told us they were happy living at Teignbridge House and felt well cared for. One person said, "It's terrific, better than a 5-star hotel." Another person said, "It's nice here, everyone is quite pleasant." People's relatives also gave positive feedback. One relative said, "They can't do enough, I think it's lovely, and it's the care that counts." Staff spoke about people fondly. One staff member said, "It's like I've got 24 grandparents."

Various opportunities were available for people to interact socially and take part in group and individual activities and hobbies. People's families commented on an improved culture in the service. One relative said, "The staff seem more dedicated now. I've seen a big improvement in the last few months, their general attitude towards the residents is better." The staff we spoke to gave positive feedback. One staff member said, "I love it here."

Improvements relating to staffing levels, supporting people to express their views, supporting people to avoid social isolation, complaints, the culture of the service and engaging people, the public and staff had been made at this inspection.

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 14 July 2023) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found whilst some improvements had been made, the provider remained in breach of some regulations.

Why we inspected
The inspection was prompted in part due to concerns received about the management of people's health needs. This included concerns around urinary catheter care and the notification of an incident following which a person using the service died. This incident is subject to further investigation by CQC as to whether any regulatory action should be taken. As a result, this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk of people's individual health conditions. This inspection examined those risks.

The provider has employed a consultant to address the shortfalls identified in the service and continues to work with the local authority to make improvements.

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

Enforcement and Recommendations
We have identified breaches in relation to safe care and treatment, consent, person-centred care, staffing, safeguarding 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
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Requires improvement'. However, the service remains 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 always safe	**Requires Improvement**
Is the service effective? The service was not always effective	**Requires Improvement**
Is the service caring? The service was caring	**Good**
Is the service responsive? The service was not always responsive	**Requires Improvement**
Is the service well-led? The service was not well led	**Inadequate**

Teignbridge House Care Home Limited

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.

Inspection team
The inspection was carried out by three inspectors.

Service and service type
Teignbridge House 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. Teignbridge House 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, however, they had stepped back from the day to day running of the service. A consultant had been engaged to oversee the safety and quality of the service, and the day-to-day operation was overseen by 2 deputy managers.

Notice of inspection

This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We reviewed information we had received from the provider since the last inspection. We used all this information to plan our inspection.

During the inspection
We spoke with 14 people and 5 relatives/friends. We spoke with 11 staff including the provider, who is also the registered manager, the consultant and 2 deputy managers. We reviewed 6 people's care records in detailed and sampled an additional 14 peoples care records. We reviewed records relating to recruitment, training, complaints, incidents and accidents, health and safety and governance.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We received feedback from 7 health professionals.

Following our site visit we contacted 19 staff by email, but did not receive any additional feedback.

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

Assessing risk, safety monitoring and management

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

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

- Risks were not always monitored or well managed.
- Pressure area care was not well monitored. 9 people were identified as being at high risk of pressure damage and needing the assistance of staff to reposition. Only 1 person had repositioning records in place, and these were poorly completed. Staff told us repositioning charts would only be put in place once a person had developed pressure damage. This meant it was not possible for managers to effectively monitor how the risk was being managed to prevent pressure damage occurring.
- Staff were required to complete daily skin checks; however, we saw multiple gaps across these records.
- Several people's care plans contained errors about the correct setting of their pressure relieving mattress. This put them at potential risk of harm.
- Systems were not in place to effectively monitor bowel management.
- 10 people were identified as needing support from staff to monitor and manage their bowels. This was either because they had a history of constipation, a medical condition, and/or a cognitive impairment which meant they were unable to manage a variable dose of laxative themselves. Whilst some records were kept, there were significant gaps in daily records and no system in place to ensure effective bowel management.
- People's weight was not effectively monitored. Whilst staff checked people's weight monthly, they did not look at weight loss or gain over a longer period. For example, one person's weight was recorded as stable, despite them having lost 7% of their weight over 3 months.
- Action plans were made when weight loss was identified, but not always implemented. We saw action plans for food charts which had not been put in place, and for fortified milk which staff told us they did not know how to prepare. Where food charts had been put in place, they had been poorly completed.
- No meaningful fluid intake or output monitoring records were kept, including for people with urinary catheters and people whose care plans gave specific direction for fluids to be monitored.
- One person used oxygen. There was no care plan in place to direct staff how to safely support them. Following our site visits a new care plan was sent to us, however, this still didn't include details of what

setting the oxygen should be on, what the persons oxygen level should be, how to use an oximeter to check it or how to clean the machine.
●Staff communicated information verbally at morning handovers, however no written record was made. This meant any issues identified might not be escalated. For example, on the first day of our inspection a staff member reported one person had been experiencing problems with their teeth for over a week. There was no evidence any action had been taken, or that senior staff had been aware of this.

Risks were not always monitored or mitigated. This potentially placed people at risk of harm. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Staff conducted a weekly call with the local GP surgery to review low level or routine concerns or follow up on any health issues. We received feedback from the GP practice that concerns were shared appropriately.
●At our last inspection, we identified significant concerns about fire safety. The provider had made improvements in line with advice from the fire service and people now had personal evacuation plans in place.
●On the second day of our inspection, new repositioning records had been put in place for those people staff identified as needing the most support.
●Pressure relieving equipment was in place and in good condition. New mattresses had been purchased since our last inspection, and mattress setting checks had recently been put in place.
●District nurses supported the service on a routine basis and told us they felt confident staff managed people's pressure area care well.
●Health professionals told us they felt confident staff contacted them at the appropriate time, and they followed their advice. For example, despite there being poor record keeping around people's food and fluid intake, professionals felt they were supported well.
●Care plans contained good information about how to safely support people with urinary catheters.
●People's care plans contained good information about what equipment they needed to mobilise, and we observed staff assisting people appropriately and safely.
●Where people were prescribed nutritional supplements, records supported that staff were supporting them to take them regularly.
●People's relatives told us they felt people's needs were well met. One relative said, "If I had to score it, I'd give it 9.5 out of 10. I'm happy with [relative] staying here."

Using medicines safely

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

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

●At our last inspection, we identified the provider failed to ensure the maximum and minimum temperature range in the medicine fridge was recorded, in line with best practice. At this inspection temperature ranges were still not being recorded.
●One person was prescribed a steroid rescue medicine. There was no care plan or protocol in place to tell staff when to use this.
●We identified one stock error in the controlled drug book. 2 staff had signed to confirm administration of

the medicine, which indicated they had not checked the stock levels before signing the controlled drug book.

Medicines were not always well managed. This potentially placed people at risk of harm. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Medicines administration systems were otherwise well managed.
●Staff recorded times of administration where required, and administration records were well completed.
●Staff recorded administration of topical creams and prescribed supplements.
●Protocols were in place for people prescribed blood thinning medicines.
●Audit systems were in place, and we could see minor errors, such as missing signatures, had been identified.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to ensure safeguarding concerns were addressed. This potentially placed people at risk of harm. This was a breach of regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

●Systems were not always effectively operated to ensure safeguarding was well managed and potential safeguarding concerns were identified.
●Staff did not always recognise what might constitute a safeguarding concern, or when they may need to take further advice from a manager.
●One person's care record said they had been distressed by another person attempting to kiss them. No incident record was completed, and no safeguarding referral was made.
●We saw records in another person's daily notes recording unexplained bruising. Staff did not complete a body map, incident record, or consider it may be a safeguarding concern, despite the person needing the assistance of 2 staff to mobilise.

The provider had failed to ensure systems and processes to safeguard people were effectively operated. This was a continued breach of regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●People told us they felt safe. One person said, "I love it here, I feel safe."
●People's families told us they also felt people were safe. One relative said they felt their relative was "very safe" and told us, "I don't have to worry about Mum."

Learning lessons when things go wrong
●Concerns about the management and monitoring of risk had been identified at our last 2 inspections.
●Staff were reactive to risk, acting when something had gone wrong, but did not always use the opportunity to widen the learning to mitigate future risk.
●For example, shortly before this inspection a health professional had raised concerns about the poor management of one person's urinary catheter bag, which put them at risk of harm. Following this, output monitoring charts were put in place overnight, however, managers did not consider that fluid output might

need monitoring over 24 hours to identify other risks, such as infections or dehydration.

Systems were not in place to ensure lessons were learnt when things went wrong. This potentially placed people at risk of harm. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At our last inspection the provider did not ensure there were sufficient numbers of staff who were suitably qualified, competent, skilled and experienced. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements relating to staffing levels had been made at this inspection.

●A dependency tool had been introduced which assessed the number of staff needed in relation to people's assessed needs. Staff rotas confirmed staffing was in line with the dependency tool.
●During our last inspection, staff raised concerns about the number of staff working in the afternoons. At this inspection, staffing levels in the afternoon had increased.
●We saw staff assisting people in an unhurried and calm manner.
●Most people told us they had help from staff when they needed it. One person said, "I rely on it, everyone is nice."
●Other people felt there could be benefit from more staff at busy times. One person said, "sometimes it takes time (for staff to be available), as they are busy."

At our last inspection the provider did not effectively operate systems to ensure fit and proper persons employed. This potentially placed people at risk of harm. This was a breach of regulation 19 (Fit and proper persons) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 19.

●An audit tool had been put in place to check recruitment processes made all appropriate checks to ensure fit and proper persons employed.
●We checked 2 staff files that had been completed since our last inspection, and both had made all the required checks.

Preventing and controlling infection

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

Improvements relating to preventing and controlling infection had been made at this inspection.

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● 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 responding effectively to risks and signs of infection
● 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.

Visiting in care homes
●Throughout both days of our inspection we saw people spending time with visitors and there were no restrictions in place.
●People's families told us they visited regularly. One relative said, "It's my second home now."

Requires Improvement

Is the service effective?

Our findings

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

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

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.

At our last inspection the provider had failed to ensure people's rights were protected. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

●People's rights were not always protected. We identified 9 people whose care records indicated a lack of capacity, but who had not been assessed, or not had decisions made for them, in line with the MCA.
●Mental capacity assessments were not being completed at the appropriate time, or about the appropriate decision. Records showed fundamental misunderstandings about fluctuating capacity, and how to use the MCA to support people in these instances.
●DoLS applications had been made without the appropriate mental capacity assessments and best interest decisions being completed.
●Some DoLS applications were made for people whose assessments stated they had capacity to consent to care.
●Consent was sought from people who did not have the legal authority to give it. For example, one person's family had been asked to consent to restricting the persons liberty with bed rails, when they did not have the

legal authority to make that decision.
●Staff recognised specific restrictions (such as bed rails or alarm mats) needed to be considered under the MCA, however, they had not actioned this for all specific restrictions in place. For example, one person used a chair that restricted their movement, no capacity assessment or best interest decision had been completed in respect of that restriction.
●People's care plans contained generic statements about capacity but did not give staff any information about that person's capacity to make decisions or how staff could support them.

The provider had failed to ensure people's rights were protected. This was a continued breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Staff had completed mental capacity act training and had recognised they needed to make improvements.

●Senior staff had attended a learning session provided by the local authority and told us they were seeking additional feedback as to how they could make further improvements.
●People were not being unduly restricted.

Staff support: induction, training, skills and experience

At our last inspection the provider did not ensure staff were suitably qualified, competent, skilled and experienced. This was a breach of regulation 18 (Staffing) 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 18.

●Staff did not always receive appropriate training and supervision.
●Staff told us, and records confirmed, they had completed training in pressure area care and mental capacity, however, we found care was not being provided in line with best practice guidance or the law.
●Several people were living with dementia, however, only 4 staff had completed dementia awareness training.
●Whilst training records were generally good, some individual staff had large gaps in their training record. This meant there were no staff who were sufficiently trained when only those staff were on duty.
●Staff had not received training around individual needs, such as how to use and maintain one person's oxygen equipment.
●Senior staff told us competency checks had been completed, however these had not been documented.
●No one to one staff supervision had taken place.

The provider had failed to ensure staff received appropriate training and supervision. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●At our last inspection there had been no training matrix to provide an overview of staff training. This had been addressed at this inspection and the training matrix showed most staff had completed the required training.
●Since our last inspection, staff had attended safeguarding, mental capacity, fire and first aid training. A small number of staff had attended specific health needs training.
●Some of the staff we spoke to told us they had completed training, and that it had been useful.
●Managers had taken part in a local hydration project, which focussed on improving hydration to reduce

infections, falls and hospital admissions.
●Senior staff told us they planned to commence formal one to one supervision in November 2023.

Supporting people to eat and drink enough to maintain a balanced diet
●People were supported to maintain a balanced diet.
●People's care records contained information about their likes, dislikes, and personal preferences. For example, several people preferred softer textured food because they found it easier to eat. One person's care record detailed they preferred to drink from a two handled beaker without a lid.
●Most people were given a choice of meals, however, one person, who chose to eat puree foods, told us,"They don't always give me a choice, I can only have what can be pureed."
●People were supported to eat where necessary.
●We heard mixed feedback about the quality of food. One person said, "Sometimes the food is a bit iffy." A second person said, "The food is excellent."
●A family member said, "I know the food's nice, because I've tried it."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

●Staff assessed people's needs prior to admitting them to the service.
●People were supported to access healthcare services and support.
●We received positive feedback from health professionals. One said, "I've provided them with some extra support, and they give me good detail (about people's needs) over the telephone."
●Another health professionals said, "I have full confidence that any health needs will be reported, and any plans I suggest will be actioned."
●Staff contacted local nurse practitioners for additional support where required. A health professional confirmed, "We have a good working relationship with them."

Adapting service, design, decoration to meet people's needs
●For most people living at the service at the time of this inspection, the design of the service met their needs.
●The service was decorated in a homely, comfortable style and people were supported to have their own belongings in their room.
●Some people, however, were limited by the design of the premises. One person was unable to use the stairlift and told us they felt isolated because their room was on the first floor.
●During the course of this inspection 2 people expressed they would like to have a bath, however, they were unable to do so because the bath wasn't accessible to them.

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.

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

At our last inspection, the provider did not support people to express their views and be involved in their care. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements relating to supporting people to express their views had been made at this inspection.

- Records showed people were supported to review their care plans on a regular basis.
- Staff held meetings where people could express their views and give feedback. We saw people had been supported to attend and their views had been recorded.

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

- People told us they were happy living at Teignbridge House and felt well cared for.
- One person said, "It's terrific, better than a 5-star hotel." Another person said, "It's nice here, everyone is quite pleasant."
- We saw that people were dressed appropriately for the season and had been assisted with personal care. People's clothes were clean, their hair had been brushed and some people had been supported to wear accessories.
- People's relatives gave positive feedback. One relative said, "Their appearance has improved, the staff are very caring, better than 6 months ago."
- A second relative said, "They can't do enough, I think it's lovely, and it's the care that counts."
- We observed staff being mindful of people's dignity. For example, one person was being assisted to mobilise using a hoist. When staff realised their clothing was being hooked up in the equipment, they adjusted it to preserve their dignity.
- On the second day of our inspection there was an event held which was busy with lots of visitors. We saw staff checking on people who might have felt overwhelmed or confused by this, to check they were okay and reassure them.
- Staff spoke about people fondly. One staff member said, "It's like I've got 24 grandparents."

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 did not ensure people's care was personalised and met their emotional and social needs. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Care plans did not always reflect people's needs and personal preferences.
●New care plans had been written for 10 people. These contained inconsistencies and errors where parts of the template used had not been personalised to the individual.
●For some people, this meant there was incorrect information about how staff should assist them. For example, two people's care plans said they needed assistance repositioning when staff said they could do so independently. Several people's care plans said they needed their bowels monitoring when staff reported they didn't, and other people's care plans said they needed food and fluids monitoring when staff said they didn't. This meant it was difficult to establish what sort of monitoring or assistance people needed.
●One person had moved to Teignbridge House in April 2023. They had initial care documents in place, but these had not been developed into full care plans. Their care notes recorded multiple occasions where they had been upset and emotionally distressed, however, their care plan didn't contain any information to guide staff as to how to support them.
●Another person's care plan said they would often become breathless and anxious but didn't contain any information about how staff should support them.
●Care plans were not always regularly reviewed to ensure they met people's current needs, and where they were reviewed no record of any changes made was kept, which made it difficult for staff to know when people's needs changed.

The provider did not ensure people's care was personalised and met their emotional and social needs. This was a continued breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Some new care plans contained comprehensive information about people's life histories and family backgrounds.
●Staff knew people well, and people told us they received good care.
●People's relatives told us they felt the care met people's individual needs. One said, "I've never had any concerns, they're very caring, and know [relatives] personality."

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 the provider did not ensure people's care was personalised and met their emotional and social needs. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements relating to supporting people to avoid social isolation had been made at this inspection.

●Various opportunities were available for people to interact socially and take part in group and individual activities and hobbies.
●Records showed a variety of group activities taking place, including quizzes, crafts, art sessions and indoor gardening.
●Some people were supported to enjoy outings, for example to the memory café, to visit the Tall Ships and to the supermarket.
●People's relatives were supported to be partners in care, some relatives confirmed they visited daily.
●On the second day of our site visit, staff had organised a charity fundraiser to enable one person to host the event, raising money selling their artwork, as they had done for many previous years in their own home. People, relatives, and friends enjoyed a cream tea and an afternoon socialising together.
●Some people had less social interaction because they chose to stay in their bedrooms. Records made it difficult to establish how often staff spent social time with those people and we received mixed feedback. One person told us they were quite happy in their own company, while another person said they sometimes felt isolated.

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.

At our last inspection the provider did not ensure people's care was based on their assessment of their needs and preferences. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements relating to meeting people's communication needs had been made at this inspection.

●People's care plans contained information about how they communicated.
●One person's care plan described how they were hard of hearing but didn't like to wear hearing aids. This helped staff understand the person might have difficulty hearing them.

Improving care quality in response to complaints or concerns

At our last inspection the complaints process was not effective to ensure a meaningful response to complaints. This was a breach of regulation 16 (Complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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

regulation 16.

●A provider audit confirmed a complaints log was now in place.
●There was no evidence any complaints had been received since our last inspection.
●We received positive feedback from people and their relatives during this inspection. One relative said, "I feel able to approach management."
●No concerns were raised during this inspection, in contrast to our last inspection when numerous family members raised concerns about the management of laundry.
●A complaints policy was in place.

End of life care and support
●People's care plans contained some information about how they wished to be cared for at the end of their life, however, it wasn't clear how personalised some of this information was.
●Because a template had been used to create new care plans for people, some information was generic and may not have been the wishes of that individual person. For example, we saw a number of care plans use standardised wording for people's wishes, such as listening to classical music.
●Relatives had shared positive feedback and thanks for the care and support their family members received at the end of their life.

Inadequate

Is the service well-led?

Our findings

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

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

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

At our last inspection systems were not effective to ensure good governance of the service. This placed people at risk of harm. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

●Quality performance, risks and regulatory requirements were not well managed.
●Following our last inspection, the registered manager, who is also the provider, took the decision to step back from their role. At the time of this inspection, they had not applied to deregister with CQC which meant they were still legally responsible.
●The provider had employed a consultant to oversee the operation of the service and implement improvements. 2 deputy managers were overseeing the day-to-day delivery of care.
●There were no systems in place to ensure senior staff and managers had oversight of daily monitoring documents. This meant managers did not have effective oversight of people's health risks.
●No written handover records were completed, which meant people's health risks were not effectively communicated.
●Senior weekly checks were scheduled to be completed every Monday, however, there were no records of these being completed between 31 August and 25 October 2023.
●Whilst some audit systems were in place, they had not identified all the areas of concern identified at this inspection. For example, managers had not identified poor monitoring around pressure area care, monitoring of bowels or the failure to assess people's capacity in line with best practice.
●Where audit systems had identified areas for improvement, action had not always been taken to address the shortfalls identified. For example, daily logbook audits completed in April, July and August 2023 all identified missing information and poorly completed daily records. They record reminding staff to complete the records fully, however at this inspection we still found multiple gaps across people's daily logbooks.
●Audit tools were not always comprehensive enough to identify risk. For example, dietary care & nutrition audits completed in August and November 2023 focussed on likes, dislikes, and food choices, but overlooked monitoring of intake. This meant they failed to identify 2 people's malnutrition risk assessments had not been completed, or that weight action plans had not been put in place.

●Care plan audits did not identify the duplication of wording, errors and incorrect information we found at this inspection. One care plan audit in July 2023 identified that more information was required about the management of one person's oxygen. This had not been actioned at the time of our inspection.
●A provider audit tool had been introduced to monitor the quality and safety of the service. This had not been used effectively and therefore did not prove useful in driving improvement. For example, the tool directed that 10% of care plans should be audited. There was no evidence this had been completed. The audit recorded there were 'gaps in information' but did not detail what the gaps were, or which care plans they were in, so staff could address them.
●The provider audit completed in June 2023 said experienced registered mental health nurses had been engaged by the consultant to improve practice around MCA/DoLS. We saw little progress had been made, despite staff also receiving face to face training from a local provider, and support from the local authority.
●Actions identified throughout the provider audit tool were vague. For example, 'development required' was used throughout, without specifying what action needed to be taken in order to develop. This meant staff didn't have clear guidance about how to make improvements.
●A comprehensive service improvement plan (SIP) had been put in place by the provider to monitor progress. We reviewed the most recent version of this, which had been shared with CQC and the local authority in October 2023, prior to our site visit. A summery said, 'internal and external audits have been frequent and demonstrated success in achieving action plan.' The SIP had assessed all actions as being completed. This meant the provider was not effectively monitoring the progress of the service.
●During this inspection, the consultant provided us with an earlier version of the SIP, which showed some areas assessed as 'amber' and needing further improvement. However, this still showed some action points, such as skin management, weight management and staff supervision marked as complete. We found this not to be the case.

Systems were not effective to ensure good governance of the service. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●A range of audits had been put in place and managers were beginning to complete them on a regular basis.
●Staff told us they had seen some improvements in the organisation of the service. One said, "There are more systems in place, duty has been covered and it's working better."
●The provider recognised further improvements were needed and told us they intended to introduce an electronic care planning system to address the shortfalls in monitoring records. They recognised this would strengthen governance processes.

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

At our last inspection, systems were not effective to ensure good governance of the service. This placed people at risk of harm. This was a repeated breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements relating to the culture of the service had been made at this inspection.

●People's families commented on an improved culture in the service. One relative said, "The staff seem more dedicated now. I've seen a big improvement in the last few months, their general attitude towards the residents is better."

●The staff we spoke to gave positive feedback. One staff member said, "I love it here."
●A second staff member said, "It's a happy place, I can have a laugh and joke with the residents."

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

At our last inspection, systems were not effective to ensure good governance of the service. This placed people at risk of harm. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities)

Improvements relating to continuous learning and engaging and involving people had been made at this inspection.

●Systems had been put in place to monitor staffs' skills and training.
●Systems had been put in place to formally involve people in their own care reviews, and to seek feedback from them.
●Staff meetings were held.
●People's relatives told us they felt comfortable giving feedback and that managers were approachable.

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; Working in partnership with others

●The provider had reported incidents to the local authority and CQC.
●The provider and senior staff continued to work with the local authority quality improvement team to address the ongoing breaches of regulation.