Care Quality Commission

Chestnut Lodge Care Home Limited

Chestnut Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service: Chestnut Lodge Care Home is a residential care home that was providing personal and nursing care to up to 15 people aged 65 and over. 15 people lived at the home at the time of the inspection.

People's experience of using this service:
Although most people and relatives told us they felt the home was safe, incidents including altercations between people were not always responded appropriately to, to help protect people from risk of harm and abuse. People's risks were not effectively managed to keep people safe at all times. We identified a breach of the regulations due to serious concerns including around fire safety, the premises and managing people's choking risks. The provider had failed to adequately learn from a choking incident and a person's death in September 2018 and people were exposed to significant risk of harm. Medicines management and infection control processes were not consistently safe. We also found staff were not always suitably deployed to meet all people's needs.

Although most people spoke positively about their care and staff told us they felt supported, people's needs were not all effectively monitored and met. The provider had sought relevant training and had further training plans underway and often sought advice and input from healthcare professionals. However, this guidance and learning was not effectively shared with staff and embedded in people's care in practice. Staff were not given clear guidance and information, to inform their knowledge and effective support to meet people's needs. People's risks were not always promptly escalated and shared with healthcare professionals to promote their health.

The provider had continued to improve the premises since the last inspection to ensure the home was safe and suitable for people. However, they had not fully considered people's individual needs, for example, they had not addressed a recommendation we made at our last inspection to ensure the environment was tailored around the needs of people living with dementia.

People spoke positively about the food but were not involved in basic choices such as menu planning. The service was not working within the principles of the Mental Capacity Act and people's choices and rights were not promoted as far as possible. Concerns identified at our last inspection had not been resolved, for example, people were still not routinely involved in decisions about their care. People's independence was promoted, and we saw examples of how people's diverse needs and preferences were recognised, however staff were still not consistently caring because people were not all treated with respect and dignity at all times.

People and relatives spoke positively about the home overall and people felt their needs were met. We saw examples of how some people's individual needs and interests were considered in their care. Care planning and admissions processes had however failed to identify all people's support needs and risks, and ensure these could be safely managed. The provider planned to improve their care planning processes including end-of-life care to ensure people's needs and wishes were captured. There had been no complaints at the

home, however relatives had submitted compliments.

People and relatives spoke positively about the provider's welcoming approach. However, we identified a continued breach of the regulations due to the provider's poor systems and oversight which failed to adequately assess, monitor and improve the service. The provider did not demonstrate sufficient understanding of good governance and had failed to identify significant shortfalls which put people at risk of harm. Sufficient improvements had not been made since the last inspection and despite previous enforcement action.

More information is in the full report.

Rating at last inspection: Requires Improvement (January 2018)

Why we inspected: We followed up on the provider's last inspection rating and to follow up on enforcement action we carried out following the last inspection. The inspection was also prompted in part by notification from the provider and Coroner, of an incident following which a person using the service died. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident. However, the information shared by the Coroner with CQC about the incident indicated potential concerns about the management of risk of choking. This inspection examined those risks. Further information is in the full report

Enforcement: After our last inspection, we carried out enforcement action to impose conditions on the provider's registration, which required the provider to submit monthly reports to the Commission in relation to their quality assurance activities. These improvements had not been sufficient to drive and sustain improvements to the provider's governance and we found further concerns at this inspection. The provider had also not always submitted their reports to the Commission as required and we prompted them to do so.

During this inspection, we took urgent enforcement action to impose further conditions on the provider's registration. This prevented the provider from admitting any more people to the home and required the provider to have our written approval for people to be admitted or readmitted to the home, and to inform us when emergency services were called for anybody living at the home.

Follow up: During and after our inspection we raised our concerns about the provider with relevant partner agencies including the local authority. We have continued to monitor the service, to request information from the provider and to liaise with the local authority.

The overall rating for this registered provider is 'Inadequate'. This means that it has been placed into 'Special Measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration, if we have not taken this enforcement action already.

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

the terms of their registration within six months if they do not improve and similar action may have been taken already. This service will continue to be kept under review and, if needed, could be escalated to further urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Care Quality Commission

Chestnut Lodge Care Home

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted in part by notification of an incident following which a person using the service died. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident.

However, the information shared by the Coroner with CQC about the incident indicated potential concerns about the management of risk of choking. This inspection examined those risks. The local authority were aware of this death at the time of our inspection.

Inspection team: This inspection was carried out by an Inspector, an Expert by Experience and an Assistant Inspector. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service, for example older people and people living with dementia.

Service and service type: Chestnut Lodge Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The care home accommodates 15 people in an adapted building of three floors.

The service had a nominated individual who was also the manager registered with the Care Quality Commission for this service at the time of the inspection. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.'

What we did: Before our inspection visit, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. As part of our inspection planning, we also sought feedback from the local

authority quality monitoring team and looked for information available from Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We referred to other information we held about the service to help inform our inspection planning. This included notifications, which contain information about important events which the provider is required to send us by law. We also reviewed monthly reports submitted by the provider, which they were required to send to us as part of our enforcement action undertaken following our last inspection.

During our inspection, 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 also spoke with 13 people living at the home and five visiting friends and relatives. We spoke with five care staff and the registered provider who is also the registered manager. We spoke with two visiting healthcare professionals and a visiting Church of England minister. We also looked at records related to 10 people's care and recruitment files for three staff members. We sampled records related to the quality and safety of the service including incident records, audits, training records, medicines management audits and charts, staffing, compliments and risk management.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.
People were not safe and were at risk of avoidable harm. Some regulations were not met.
At our last inspection we rated this key question 'Requires improvement'. At this inspection, we have rated this key question 'Inadequate'.

Assessing risk, safety monitoring and management;
Learning lessons when things go wrong

- A Coroner's report in January 2019 described the provider's poor response to and learning from, a person's death in September 2018 after a choking incident at the home. Our inspection found people were still exposed to this level of risk due to poor risk management.
- One person had a known increased risk of choking. Staff did not all know, and had not been given accurate guidance about how to safely prepare the person's meals and drinks. The person was served food deemed 'high risk' to them and despite our prompt, the provider and cook did not see this as a risk.
- The provider's risk assessments instructed staff to serve this person foods which healthcare professionals said would put the person at high risk of choking. The provider told us this was because they had misunderstood this guidance.
- We saw a second person frequently coughed during mealtimes. These concerns had not been reported or logged by staff as required to help monitor the person's risks and keep them safe.
- Staff told us when concerned about this person's coughing, they opted to give the person someone else's prescribed thickener to help them swallow with more ease. This was inappropriate and unsafe practice which placed the person at risk and failed to manage their risks safely.
- Despite our input and additional advice from a healthcare professional, this person's risks were still not effectively monitored and responded to during mealtimes over the course of the inspection.
- The person had been advised to avoid a certain food since February 2019 due to a choking risk. We saw the person still had this food.
- The provider had failed to ensure correct, clear and consistent guidance was in place for both people, and to seek healthcare advice for both people's ongoing concerning symptoms.
- These shortfalls in safety demonstrated the provider's failure to help prevent future choking incidents and deaths. We needed to intervene and prompt the provider to address these, and additional concerns over the course of the inspection to help protect people.
- Systems did not keep people safe in the event of an emergency. Emergency services were called due to concerns about one person's health. Staff could not open either entrance to the home because they did not know the keypad code and did not have immediate access to keys to unlock the doors. Although this could have delayed paramedics' entry, the provider did not identify this as a safety priority and we needed to prompt them to immediately assist staff.
- Although fire drills and health and safety checks were carried out, people's personal emergency evacuation plans were poorly completed and/or unavailable.
- As at our last inspection we found most people's walking aids continued to be stored away from them, out of reach. We saw one person at risk of falls, struggled to walk safely and independently without their frame

and staff support. The provider failed to identify this as restrictive and unsafe practice and to ensure it did not happen again.

● Risk management was not robust although some staff showed awareness of people's risks. The provider's oversight including the quality of risk assessments failed to ensure people's risks were adequately assessed, monitored and managed to ensure their safety.

● The above concerns demonstrated a failure to prevent avoidable harm or risk of harm which is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These concerns contributed to our decision to take urgent enforcement action during our inspection and to liaise relevant partner agencies including the fire service and the local authority.

Systems and processes to safeguard people from the risk of abuse

● Most staff were trained and knew how to identify and report safeguarding concerns however this was not consistent for all staff we spoke with.

● Some people and staff told us that some people had had verbal altercations. No such incidents had been recorded or effectively monitored to identify possible risks to people's safety and wellbeing. This did not protect people from harm as far as possible. We raised these concerns with the local authority for further review.

● Most people and relatives told us they felt the home was safe. Comments included: "I feel safe here," and, "They are very good. [My relative] is safer than they have ever been."

Using medicines safely

● People's medicines were not always managed safely. For example, one person was prescribed PRN pain relief to use 'as and when' they experienced pain. We found the person often expressed pain and had taken up to the maximum amount of PRN pain relief over at least 16 days. We prompted the provider to share this information with a doctor as they had not done so.

● The provider's PRN processes and guidance did not meet current good practice standards, for example to be regularly reviewed.

● People were not always told what medication they were taking, observed taking their medicine or given space to take their medication discreetly.

● Staff had, however undertaken training and medicine storage arrangements helped promote safe practice. Medicines records we sampled were completed accurately. One person told us, "When I am in pain, they give me tablets".

Preventing and controlling infection

● Despite some improvements, practice was not consistently safe.

● Since our last inspection, the provider had improved cleaning and laundry facilities and introduced regular infection control audits.

● Continence waste resources were only available on one of three floors which did not promote people's dignity and good hygiene.

● People told us, "The home is clean and comfortable," and "Very clean". Staff had received relevant training about infection prevention.

Staffing and recruitment

● Staff were not always suitably deployed. Staff were often available to promptly support people in one communal area, but people often spent time alone in another lounge area. We saw staff only tended to come into this area to offer task-based support.

● People told us their call bells were responded to, but not always in a timely way. One person told us, "They respond to the bell generally promptly, depends how busy [they are]."

● Following our prompts at the last inspection, the provider had improved their recruitment processes with support from the local authority. They told us they had repeated Disclosure and Barring Checks for all staff. Records we sampled showed appropriate recruitment checks had since been carried out before staff started in their roles.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence. There were widespread and significant shortfalls in people's care, support and outcomes. Some regulations were not met.
At our last inspection we rated this key question 'Requires improvement'. At this inspection, we have rated this key question 'Inadequate'.

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

- The quality and safety of support provided was inconsistent, particularly for people with more complex needs, whose needs were poorly monitored and understood.
- Although the provider sourced healthcare advice and specific training for some people's individual needs, this guidance was not always applied to people's care planning or support.
- Gaps in staff knowledge about people's needs, and gaps in the guidance made available to staff, meant care could not always be effective. Staff did not know how to safely prepare meals and drinks for two people at increased risk of choking and clear guidance was not available to staff until we intervened.
- People's care records contained limited information about how to identify and respond to other support needs, including behaviours that may challenge and equipment use. This did not ensure people's needs would always be understood and effectively met by staff.
- Kitchen staff lacked sufficient knowledge of people's dietary risks and preferences, including a person's religious needs. Another staff member didn't know about two people's needs associated with their mental health. They stated, "You know, I don't know," when referring to one person and did not know about monitoring support to ensure the second person's safety.
- People told us, and records showed people were often supported to access healthcare support when needed. A person told us, "I see the doctor if I need to." However, the provider failed to ensure healthcare professional advice was always clearly and accurately recorded in people's care plans. One person was advised to avoid a certain food by healthcare professionals, however their risk assessments inaccurately stated they enjoyed this food, with no reference to the risk it placed them at.
- After we had prompted the provider to correct this person's risk assessments, we then needed to prompt the cook to read this information because they had not done so as requested. This meant the cook remained unaware of this risk until we ensured they had read about it. The provider had also left an outdated and incorrect risk assessment in the person's main care plan.
- At our last inspection, we stated the provider should refer to current good practice guidelines, to support improvements to dementia care planning and to ensure the design of the home was developed according to all people's needs. We found no action had been taken.
- The provider could not demonstrate they had sought such guidance or followed this recommendation. For example they told us they had a displayed a clock by way of tailoring the home's design to the needs of a person living with dementia. This failed to fully acknowledge our recommendation and to recognise people's needs and experiences, and to promote positive experiences as far as possible.
- The provider had not ensured the needs of people living with dementia were consistently met and

understood. When one person often asked after a loved one, some staff continued with an ineffective response although they told us they knew it caused the person upset and distress. Over half of the staff had not received training related to dementia care.

● Poor communication and monitoring delayed some people's access to healthcare support. We needed to prompt healthcare referrals, for example where staff had given one person someone else's prescribed thickener instead of reporting the person's health concerns.

● After the inspection, a person's family had complained after they were not informed by the home of the person's admission to, and unfortunate death in hospital.

● However, people described their care as, "Okay" or, "Very good". Some other relatives spoke positively about the support provided and we saw examples of positive and effective support.

● A visiting healthcare professional told us, "Staff seem to know [person] and seem quite caring. They always give me care plans etc., and a readily available medication list."

Adapting service, design, decoration to meet people's needs

● At the last inspection, we stated the provider should review the design and décor of the home to meet all people's needs. We found sufficient action had not been taken.

● People's support needs and comfort were not considered as far as possible. One person strained to watch television as it was positioned behind them. Another person commented aloud to staff, "I think [person] gets a stiff neck." Staff did not respond to either person. We prompted the provider to review the layout of the lounge area which helped address this issue.

● We prompted the provider to review the safety of their premises as they had not identified risks and restrictions.

● Home renovations had continued since our last inspection. A visitor told us, "Physically the home is much better, new décor, chairs, floors and so on… More modern ones are purpose built but the informality [here] reminds us it's people's home."

● The provider could not demonstrate they had acted on our recommendation related to décor from the last inspection to consider the needs of people living with dementia.

Ensuring consent to care and treatment in line with law and guidance

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

● People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. 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 any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

● The service was not working within the principles of the MCA and people's choices and rights were not promoted as far as possible.

● At our last inspection, we saw the provider routinely stored people's walking frames away from them. Although we had brought this concern to their attention, the provider had carried on this unsafe practice and failed to understand how it restricted people from moving as they wished.

● Although the provider told us a plan was in place to monitor one person's whereabouts for their safety, there was no record of this plan and staff we asked were not aware of how to safely support the person and why. After an incident in the community where this person was put at risk, the provider applied for an urgent DoLS to ensure the person's safety moving forward.

● Most staff showed some understanding of the MCA however could not tell us who had a DoLS authorisation or application in place and why.
● However, feedback we received, and most of our observations confirmed people's consent was sought. A person told us, "[Staff] always explain first," and a relative told us, "They ask for permission and get consent," in relation to people's personal care.

Staff support: induction, training, skills and experience
● Following a serious incident, the provider had updated their First Aid training and developed a training policy. However continued poor management and record keeping prevented the consistent safe management of people's risks.
● Since the last inspection, the provider had provided relevant staff training and updates including about the Mental Capacity Act, diabetes care, safe moving and handling, infection control, fire safety and equality and diversity. The provider had also enrolled some staff onto further care qualifications.
● A new staff member told us they had completed their induction, which involved shadowing and completing the Care Certificate. The Care Certificate sets out the minimum common induction standards for all staff new to social care.
● A new Care and Support Officer had recently joined to provide more staff support and oversight. They had experience in supporting care staff through the Care Certificate and relevant care qualifications.
● Staff told us they felt supported and had enough training for their roles.
● The provider had further training planned in relation to falls management, nutrition and hydration, behaviours that may challenge and dysphagia as staff had not all yet received this.

Supporting people to eat and drink enough to maintain a balanced diet;
● People liked the food. One person said, "The dinners are excellent." However, another person told us, "If you ask for some more [food], you don't quite get it." The cook told us, "I do normally ask them if they want more… today I haven't got around to it."
● Although varied meals were served and reflected people's known preferences and healthier options, people were still not involved in selecting and developing menus to ensure their preferences were met as far as possible.
● Relatives told us, and we saw, people were offered enough to drink.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect
People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.
At our last inspection we rated this key question 'Requires improvement'. At this inspection, we have rated this key question 'Requires improvement' again.

Supporting people to express their views and be involved in making decisions about their care
● Our last inspection found people were not involved in their care as far as possible. The provider told us these improvements were underway, but we found this was inconsistent and processes were not robust.
● Due to risks identified during our inspection, one person was no longer served toast as it presented a choking risk. The person mentioned to three different staff members that they missed their toast, but no one explained the reason for this change to the person.
● People were still not routinely involved in menu planning beyond stating their preferences when they first joined the home. One person told us, "We don't always have a menu choice but if you don't like the food, they do their best." Six people provided similar feedback.
● Residents' meetings were regularly held to help seek people's views and feedback. Relatives told us they were kept informed and involved in these meetings and care planning processes.
● Records we sampled showed some people had been asked for their views about their care. One person had expressed they were happy and felt supported by staff when needed. Another person told us, "They always encourage us to give suggestions."

Ensuring people are well treated and supported; respecting equality and diversity
● Staff did not always demonstrate a caring approach, for example some staff often stood and watched people and did not use available opportunities to talk and spend meaningful time with people.
● In another example, a staff member moved a person's chair without their consent and although the person had cried out in pain. The staff member failed to treat this person with compassion and understanding when they remained unsettled. The staff member continued to stay and support the person although the person stated, "Please stop it, leave me alone." We informed the provider and local authority of these concerns for further investigation.
● Most of our observations found an improved approach since our last inspection, and people were often treated with kindness and care by staff. Staff addressed people by their names and often spoke to people with respect.
● Staff spoke different languages to support people where their first language was not English.
The provider had sourced films and music reflecting people's cultural and language needs.
● People were supported to follow their religious practices, such as attending services in the community. People responded well to a visit from a Church of England minister who commented, "[The provider] has brought people along to different things we've organised and is very welcoming to us."
● People and relatives described the home as warm, friendly and homely. A relative told us, "They are smiling and welcoming. All the time I come whatever time I want."

● We saw staff often built up rapports with people. Some people told us they had made some friends. The provider regularly brought their dog to the service which people enjoyed and responded well to. One person laughed and chatted to the dog and patted them.
● People and relatives gave mostly positive feedback about the approach of staff. Comments included: "They are very patient;" "They treat me with dignity and respect;" "I find them very pleasant."
● Some relatives' feedback suggested staff were not consistently caring: "Some are very caring some more than others"; "I think on the whole they are caring."

Respecting and promoting people's privacy, dignity and independence
● As at our last inspection, people's medicines were administered in communal areas and during people's mealtimes. This practice still failed to promote people's privacy or positive experiences as far as possible.
● A relative told us, "[Person] is very well looked after, always well-dressed the way they used to like it."
● People told us they were helped only when needed to promote their independence. People's comments included, "I want to stay independent, they only help when necessary," and, "I like to do some of the things by myself."
● People told us they were treated with respect. One person told us, "Very respectful, they always knock on the door before they enter."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs
People's needs were not always met. Regulations have been met.
At our last inspection we rated this key question 'Requires improvement'. At this inspection, we have rated this key question 'Requires improvement' again.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
● The provider's care planning processes failed to identify all people's support needs and risks, and how these could be safely managed.
● One person's background information and risks showed they required additional support and monitoring to remain safe. The provider had not fully considered this information or involved the person and relevant others in care planning to ensure the person's safety and wellbeing as far as possible. We had to prompt the provider to find out significant information about this person, although they had lived at the home for over three weeks at the time of the inspection.
● Whilst the provider had recognised the Accessible Information Standard, this had not led to consistent staff practice. This standard sets out a specific, consistent approach which includes meeting the communication support needs of people with sensory loss and impairment. Staff failed to promptly communicate with a person who was unsettled, in a way to reassure the person and help them understand. The person stressed, "I can't hear you, I can't hear you," and became more unsettled before staff opted to use the person's cue cards.
● Relatives spoke positively about the home although some people who lived there gave mixed feedback. One person told us, "It's great here, I like my home." Another person told us, "It's generally good: they look after you, feed you, I suppose so but I just accept things as they are, it's expensive, they are coping best they can."
● People often responded well to group activities or followed their own hobbies and interests such as reading, gardening and knitting. One person told us, "There's enough to do, activities, games, a walk in the park." Another person told us, "We watch interesting things on telly, there is singing, colouring, board games and other activities." There were periods however where people sat with little to do.

Improving care quality in response to complaints or concerns
● People told us they had never complained as they did not need to. A relative also told us, "If I had a complaint, I would talk to the manager." One person told us, "You could say if you were not happy, of course."
● The provider told us there had been no complaints. Despite feedback at our last inspection, the provider had not reviewed or improved their complaints process however people and relatives could complain if they needed to.

End of life care and support
● The provider told us they had completed end of life care planning with people. Records we sampled reflected this. Further conversations were underway with people and relatives for those who had joined the home more recently.

● The provider had requested a review with the doctor to support one person with decisions about this aspect of their care.

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
There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.
At our last inspection we rated this key question 'Requires improvement'. At this inspection, we have rated this key question 'Inadequate'.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility;
Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider did not demonstrate understanding of good governance and requirements to ensure the quality and safety of the service, for example, in relation to auditing and risk management including fire safety.
- Audits were not carried out robustly to ensure records were accurately maintained to reflect people's current needs.
- The provider failed to ensure staff were aware of their responsibilities and risks in order to help keep people safe and well. We had to prompt the provider to address a number of shortfalls in risk management including around choking risks, the premises and informing staff of risks.
- The provider failed to learn from a choking incident and death of a person using the service which was referred to the Coroner. Despite our prompts during the inspection, the provider's continued poor systems and understanding put people at continued risk of significant harm.
- A combination of poor systems and processes failed to keep people safe, including in relation to risk management, staff training, record keeping, fire safety and learning from incidents.
- The provider failed to adequately assess, monitor and improve the quality and safety of the service, including our previous inspection concerns and a recommendation in relation to the quality of dementia care.
- The above concerns demonstrated a continued failure to have sufficient oversight and governance systems to ensure the quality and safety of the service. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These concerns contributed to our decision to take urgent enforcement action during our inspection and to liaise relevant partner agencies including the fire service and the local authority.
- We prompted the provider to display the correct registration certificates which reflected the enforcement action taken following our last inspection. The provider had made a copy of the report available to people and visitors which displayed their rating.
- Although the provider took remedial action during and after the inspection to address concerns about people's safety, this was reactive and the provider's own oversight had not identified and avoided these risks to always ensure people's safety.
- We were told altercations had occurred between people however the provider's systems had failed to monitor and manage these risks, to protect people and ensure relevant partner agencies including CQC,

were always informed of events as required.

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

- Relatives told us they felt involved in people's care, however improvements to involve people in their own care were not robust.
- Relatives felt their feedback would be addressed. Comments included: "If I have had some issues and spoke to management, things will change," and "Management is good, if anything happens, they sort it. They were able to resolve my query to satisfaction."
- People and relatives described a warm and friendly culture at the home and spoke positively about the provider.
- Records we sampled showed people and relatives had given consistently positive responses to the provider's surveys about the home. We also saw compliments submitted by relatives about people's positive experiences.
- The provider had fostered good and genuine relationships with people living at the home and their relatives, who showed they valued the provider's caring and welcoming approach.
- A new Care Support Officer had recently started to support the provider's oversight and help to drive improvements. This included taking remedial action to investigate two recent incidents.
- The provider sought support from relevant partners such as the fire service and pharmacy.

Continuous learning and improving care

- At our last inspection, the provider had developed a new system to analyse incidents to help identify how to improve people's safety and prevent future reoccurrences. We saw this improvement had not been sustained.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to prevent avoidable harm or risk of harm.

The enforcement action we took:

We served an urgent notice of decision to impose conditions on the provider's registration. Further enforcement action is underway.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider continued to fail to have sufficient oversight and governance systems to ensure the quality and safety of the service.

The enforcement action we took:

We served an urgent notice of decision to impose conditions on the provider's registration. Further enforcement action is underway.