Chaston House Ltd

Chaston House Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
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
Chaston House Care Home is a residential care home providing personal care to up to 11 people aged 65 and over. At the time of the inspection, there were nine people using the service.

People's experience of using this service and what we found
At our last inspection on 24 January 2019, we issued a breach of Regulation 19 because the provider had not sought references for some staff employed by the service and had relied on previous employers' checks. At this inspection, we found improvements had been made in relation to this. However, we found other areas of concern.

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.

Risk assessments and support plans were inadequate and did not support staff to ensure people received safe care. People told us they felt safe; however, the systems in place did not always protect people from avoidable harm. There was no learning from incidents and accidents and people were not always protected from the risk of reoccurrence. People were not protected from the risk of infection and cross contamination. Staff did not always follow the provider's health and safety and fire policy and procedures and there were significant safety risks identified during our inspection.

The provider did not always ensure there were sufficient staff to meet people's needs. This increased the risk of people's needs not being met in a timely way and placed people at risk of harm.

People were not always treated in a kind and dignified manner. The staff worked in a task-focussed manner and did not always meet people's needs or consult them in relation to what they wanted to do. Staff did not always know people as individuals and were not always aware of their needs. People's communication needs were not always met.

Care plans were not person-centred, were inconsistent and did not always guide staff to provide person-centred care. People were at risk of social isolation and did not engage in community activities. There were few activities taking place, and the activities on offer did not meet people's needs. The environment and activities had not been developed to meet the needs of people living with dementia.

The provider's quality monitoring systems were inadequate as they had failed to identify the shortfalls we found during our inspection and had not ensured people were always kept safe. We found the service failed to demonstrate they were providing care and support that was safe, caring, effective or responsive. This put people at risk of harm.

Overall people received their medicines as prescribed. However, staff did not always follow the provider's medicines policy in relation to medicines to be given 'as required'.

People's healthcare and nutritional needs were met, although mealtime was not always a positive experience for people who used the service.

Staff were supervised and received an induction and relevant training to help ensure they could provide effective care.

The provider acted in accordance with the requirements of the MCA. The service worked well with other health and social care professionals who spoke well of them.

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

Rating at last inspection
The last rating for this service was requires improvement (published 5 March 2019) and there was one breach 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 enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement
We have identified breaches in relation to safe care and treatment, staffing, person-centred care, dignity and respect and good governance at this inspection. We also issued two recommendations in relation to the environment and the management of medicines.

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 request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore 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 rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as

inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
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**

Chaston House Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by one inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Chaston House 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 service had a manager registered with the Care Quality Commission. 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.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since our last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with nine people who used the service and four relatives about their experience of the care

provided. We spoke with five members of staff including the deputy manager, supervisor, senior care worker and care workers.

We reviewed a range of records. This included four people's care records, incidents and accidents and medicines records for all the people who used the service. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We emailed two professionals who regularly visit the service and received feedback from them.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate.

This meant people were not safe and were at risk of avoidable harm.

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

- Where incidents and accidents happened, appropriate action was not always taken to prevent these happening again, and lessons were not always learned. For example, we saw that one person had fallen on a number of occasions. On 24 November 2019, the registered manager had recorded a sensor mat was in place to alert staff when the person was getting out of bed, thus preventing them from falling.
- We asked the deputy manager if the sensor mat was in place. They told us this was on order. They explained that a previous mat had broken and they had ordered a new one. However, they were unable to show us evidence of this. The person's relative told us they had asked on many occasions where the mat was and had been told it was on order since the accident. This meant people were not always appropriately protected from avoidable harm.
- Incident records showed that the person had fallen on 17, 19, 24 and 25 November 2019. On the incident record of 19 November, the registered manager had recorded, 'Staff will have to keep a very close eye on [Person]'. The record on 21 November stated the person needed to be 'supervised at all times'. However, there was no specific plan on how to do this, for example, one to one monitoring. This meant the person had continued to sustain unsupervised falls. Furthermore, no other action had been taken, such as referring the person to relevant professionals and seeking support for them. We raised our concerns with the local authority's safeguarding team.
- Not all risks to people's safety and wellbeing were assessed and recorded, and there were not always guidelines for staff. For example, a person was living with diabetes, but there was no risk assessment in place in relation to this, and no guidelines were available for staff to know how to support the person should they become unwell. We raised this with a member of staff who displayed a lack of knowledge about the person's condition and was unable to tell us how they supported them to remain well apart from, "[They are] on medication."
- A senior staff member told us the person had been at the service for a long time, and there had never been any issues about their condition. However, they were unable to tell us how they would recognise signs the person's condition was changing or deteriorating.
- One person was at risk of pressure ulcers. The person was provided with a pressure mattress to help prevent the development of pressure ulcers, but there was not a skin integrity support plan or monitoring chart in their care records. The care plan instructed staff to check the person's skin condition and report any issues to management. However, there were no guidelines about how to recognise signs of skin deterioration, and staff did not record their observations.
- We found a number of safety concerns during our check of the environment. There was a room downstairs near the kitchen which contained the medicines cabinet, a cupboard for coats and bags, a shower room and

a small cupboard, containing a range of products. We found two cleaning products left on the floor of the shower room. The small cupboard was unlocked although it contained products such as prescribed creams and aerosol sprays. A member of staff told us this should have been locked. We raised this with a member of staff who removed the cleaning products and locked the cupboard.

● . One of the doors upstairs leading to a bedroom had a broken handle which left a sharp edge. This could cause an injury to a person trying to open the door. Due to the broken handle, staff were preventing the door from closing with a towel on the floor. This presented a possible trip hazard. We discussed this with a staff member, who told us the handle had been broken for a few days, and they were hoping it would be repaired soon. They added that they needed to put the towel on the floor, otherwise the door would close, and people would not be able to get out. They added, "That would be very bad."

● There were regular fire checks undertaken and people had personal emergency evacuation plans in place. However, we could not be sure people were suitably protected from the risk of fire because staff were not following good practice, in line with the provider's fire policy. For example, a fire door leading to the lounge was being propped open with an armchair, and we saw the door guard was not working. A staff member told us, "I keep telling them, but nothing is done." We raised this with the deputy manager, who said they could not close it, as they had to monitor the people sitting in the lounge. The door leading to the room containing the medicines cabinet, also a fire door, was being propped open with a cloth. We raised this with a member of staff who kept this closed for the rest of the day.

The provider had not ensured that all reasonably practicable steps were taken to mitigate risks to people and to follow good practice guidance to make sure the risk was as low as is reasonably possible to people. This is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

Preventing and controlling infection

● People were not always protected from the risk of infection and cross contamination. At meal times, we noticed that none of the staff used personal protective equipment such as gloves or aprons and were handling people's cutlery with bare hands. Some people used their hands to eat their food but were not supported to wash their hands before their meal.

● We saw some care staff wearing long acrylic nails which raised the risk of cross contamination and a risk to people's skin. We fed this back to the deputy manager on the day of our inspection and the registered manager after our inspection.

● Overall the home was clean and we saw staff cleaning bathrooms, toilets and bedrooms during the morning. However, some window sills were dusty and some paintwork chipped and damaged.

One person's bedroom had a large area of heavily stained flooring. We asked a member of staff what caused this. They replied a person used to be incontinent all the time, and this had damaged the flooring. However, no action had been taken to replace this.

The provider had failed to protect people from the risk of infection and cross contamination. This is a 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, we found that recruitment practices were inconsistent. At this inspection we found improvements had been made in this area and recruitment checks were carried out appropriately. However, we found other areas of concerns in relation to staffing.

● On arrival at the home, there were three care staff on duty. They told us the registered manager and provider were away on holiday, and the deputy manager would be in later. They arrived at 13.00. The three

staff members were responsible for cooking, cleaning and taking care of 11 people. This meant there was little time for them to spend time with people or organise any activities.
● Staff were busy and rushing around. This meant people were left largely with nothing to do but sit and wait. There was very little interaction apart from a member of staff occasionally bringing drinks for people or spending a minute or two helping with a puzzle whilst standing over the person.
● The deputy manager told us they occasionally required the use of agency staff. They said, "It is only sometimes. Most of the time we are fully staffed." The staff rota indicated all shifts were covered, but as care staff were also responsible for cooking and cleaning, there were times when people's needs were not met.

The provider had not ensured that there were sufficient staff to meet people's needs. This increased the risk of people's needs not being met in a timely way and placed people at risk of harm. This is a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities).

● Despite our observations, people told us they felt safe with the staff who supported them. One person said, "I feel safe because staff are here all the time." Staff told us usually members of the management team were around and helped. However, on the day of our inspection, this was not the case.

Using medicines safely
● There was a medicines policy and procedure in place and staff were aware of these. Staff received training in the administration of medicines and had their competencies assessed. Medicines were kept in a locked medicines trolley in the downstairs room. Room temperatures were recorded each day and were documented as being within safe range. However, we noticed the thermometer used to record the temperature was broken. We notified a member of staff who told us they were not aware. This meant we could not be sure the recorded temperatures were accurate.
● Some people were prescribed medicines to be taken 'as required' (PRN) and these were supplied in their original packaging. However, staff had not recorded the date of opening on the packs and did not keep a running count of the medicines. This meant it was not possible to accurately audit these. We raised this with a member of staff who told us they were supposed to put a date of opening on boxes but had not done this.
● People's medicines were recorded on Medicine Administration Record (MAR) charts. We viewed the MAR charts for all the people who used the service and these were completed correctly by staff, indicating people were given their medicines as prescribed. Most medicines were supplied in dossett boxes by the pharmacist. We saw evidence that medicines had been given according to instructions.
● There were no controlled drugs at the time of our inspection. However, the provider had a double lockable cupboard to store these should they need to. Controlled drugs are tightly controlled by the government because they may be abused or cause addiction.

We recommend the provider seeks relevant guidance in relation to medicines supplied in their original packaging and those to be given as required.

Systems and processes to safeguard people from the risk of abuse
● There was a safeguarding policy and procedures in place and staff were aware of these. The provider sent notifications to the local authority when there was a safeguarding concern and worked with them to investigate and put systems in place for the protection of people who used the service. Staff received training in safeguarding adults and understood how to protect people from abuse.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- Some people who used the service were living with dementia. We saw the colour schemes, lighting and additional features did not reflect good practice guidance for environments for people living with dementia. There was no signage to help people find their way to different areas of the home. Bedroom doors displayed the room number, but there was no photograph or name of the person.
- An attempt had been made to use sensory equipment such as a sensory bubble tube, but this was no longer in use, and was stored in a corner of the room. There were no other sensory or tactile objects in use, and most people were in a disengaged state throughout the day of our inspection.

We recommend that the provider seek relevant guidance in relation to improving the environment to meet the needs of people living with the experience of dementia.

Staff support: induction, training, skills and experience

- People and relatives thought staff were well trained and were skilled. One relative stated, "They are properly trained and seem to cope alright when we are here."
- People were supported by staff who received regular training and supervision. All staff received training in courses the provider identified as mandatory, such as safeguarding, health and safety, moving and handling and medicines. Staff files contained training certificates to evidence training undertaken. However, they were not always trained in subjects specific to the needs of people who used the service, such as dementia, diabetes and end of life care. This meant they might not always know how to support people and meet their needs.
- One staff member told us they undertook their own training and said, "I love training. I go looking for it and do it. I did end of life training."
- New staff received an induction into the service before they could support people. This included reading policies and procedures, an introduction to people who used the service and the building, and shadowing more experience staff members. They were supported to undertake the Care Certificate. The Care Certificate is a nationally recognised set of standards that gives staff new to care an introduction to their roles and responsibilities.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs were assessed before they started using the service, to help ensure staff could meet these.

The care plans were written from the initial assessments. Initial assessments included details of the person, their likes and dislikes and how they wanted their care delivered. However, these were not always effective as they had not considered people's needs in relation to end of life care, dementia and sexuality.

Supporting people to eat and drink enough to maintain a balanced diet

● People's nutritional needs were met. People told us they enjoyed the food on offer. One person said, "The food is good which is important." Staff told us they consulted people about the food they wanted to eat and cooked meals according to their choices. At lunchtime, we saw people enjoying their meals. They were offered good portions and ate everything on their plates.

● People's nutritional needs and food likes and dislikes were recorded in their care plan. We saw a board in the kitchen stating people's individual nutritional needs, to help ensure these were respected and met.

● Staff cooked meals according to people's taste and they were offered choice on the day. Staff told us people who had cultural preferences in terms of meals were offered dishes they enjoyed, for example curries, and vegetarian meals.

● People were offered drinks regularly, and a sign in the kitchen reminded staff to offer regular drinks to people. There were jugs of drinks in the communal lounge so people could help themselves if they could. We saw staff offering regular refreshments to people.

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

● People's healthcare needs were assessed, recorded and met. People were supported to maintain good health including oral health, and had access to healthcare professionals, including GPs, dieticians and district nurses.

● The staff worked well with other healthcare and social care professionals to meet people's needs. People were supported to attend appointments such as doctors' or hospital appointments. One person told us, "You get a cab. One of the girls will come with me." A healthcare professional, whose client had passed away, told us, "My client was comfortable and content at Chaston House and the home were conscientious about involving outside professionals when needed."

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 when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● Records were kept electronically and unsigned so there was no evidence people had been consulted and agreed with these. However, we saw people's consent was obtained verbally by staff throughout the day, before any support was offered.

● People's mental capacity was assessed before they began to use the service, and we saw evidence of

mental capacity assessments in people's files. The provider understood their responsibilities under the MCA. Where necessary, they had made applications to the local authority for authorisations to deprive people of their liberty in order to keep them safe. At the time of our inspection, nobody was being deprived of their liberty unlawfully.

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.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence

- People were not always treated with kindness and compassion by staff when they supported them, as their approach was task focussed. Throughout the inspection, people were left sitting in the lounge/dining room. Staff came in and out, supporting people with personal needs as they needed, but we saw that often, people were left unattended.
- One person had lived at the home for two weeks and spent most of the time in their room. When discussing the person with a member of staff, we found they did not know the person's name.
- People appeared disengaged and bored. One person kept humming to themselves, looking around. Another person kept shouting, and another telling them to 'shut up' but staff did not intervene or try to find something for the person to do to offer a distraction.
- Throughout the morning and lunchtime, the radio was on, playing pop music with talks in between. This contributed to a chaotic atmosphere. Furthermore, nobody was consulted in relation to whether they wanted to listen to the radio, or if they had any preferences in terms of music.
- During lunch, we saw staff placing people's food in front of them without a word or informing them what the food was and if they were happy with this. There were no condiments on tables and people were not provided with serviettes or clothes protectors.
- Mealtime was interrupted by a dispute between two people. We saw staff seemed unable to manage this situation effectively. For example, one person was wandering around the room picking up other people's plates of food, but staff were unable to meet this person's needs and this continued throughout lunchtime. This meant where one person was being supported with eating, this was interrupted.
- We saw staff brought mugs of drinks prepared in the kitchen for people who used the service. We did not see them consulting people about what they wanted to drink.
- The provider had an equality and diversity policy in place, and staff received training in this. However, this did not contain information about people's needs in relation to their sexuality so they could support people and staff who may have specific needs in this area. At the time of our inspection, the registered manager told us they did not support people from the lesbian, gay, bisexual and transgender (LGBT+) community.

People were not always well supported and respected. This was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● However, people told us the staff were caring and respected them. One person said, "They're very nice people. I am quite comfortable." They added staff always knocked on their door before entering, asked their permission and respected their privacy and dignity. One relative told us, "My [family member] is happy. [They are] well looked after. We have no concerns."

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to 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; 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

- Care plans were kept electronically and were developed from the initial assessments. Staff had access to these on a tablet and had their own password. However, the care plans lacked detail, were not person-centred and did not always contain enough information so staff would know about each person and how to meet their needs. The care staff on duty were not always able to navigate through the electronic care plans and found it difficult to find information we requested.
- We did not see evidence that people and/or relatives were involved in their care plan. People were not able to confirm if they were. Two relatives told us they had not been involved in care planning.
- People who used the service did not have access to meaningful activities, particularly those living with dementia. Throughout the inspection, we saw people sitting in their armchairs. Some had a table in front of them where staff placed either a puzzle or children's colouring books and crayons. The only brief interactions we saw involved a staff member helping a person find some puzzle pieces and another encouraging someone to colour a picture of Bambi.
- People showed very little interest in the activities and looked disengaged. Some eventually gave up and fell asleep.
- One person walked around the lounge/dining room almost continually, occasionally trying to open the door leading to the garden, but nobody attempted to support them to go outside for a walk. Overall people looked bored and had little to do. The radio was on throughout the morning, with a mixture of talk and pop music.
- None of the people who used the service had a personalised activity plan. There was an activity board in the lounge which only had one activity displayed, such as exercises on a Tuesday.
- Staff told us they sometimes took one of the people out to the shop. When asked if other people went out, a staff member said, "No they don't go anywhere." One person told us, "I get a bit bored sometimes." Following the inspection, the registered manager told us people did not wish to go out, so they did not force them. However, no effort was made to find out what people enjoyed doing.

The provider had not always ensured that the care and treatment provided to people was appropriate, met their assessed needs, or reflected their preferences. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

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

● People's communication needs were not always recorded in their care plans. For example, one staff member told us how they communicated with a person who had lost the ability to speak their own language following a health condition. However, the person's care plan did not contain any information in relation to this. Our observations on the day of our inspection was that the person easily became distressed and although staff tried to comfort the person, they did not know how to communicate appropriately with them or reassure them.

● Another person for whom English was not their first language had difficulties expressing themselves. We did not see staff using other methods such as using pictures or words to communicate with them. Instead, they kept asking the person to 'speak English'. A staff member told us the person understood English but did not speak it.

● A third person who was visually impaired told us they listened to the radio and took part in exercises, but there was nothing organised to support them with their impairment. We asked them if they had access to talking books. They told us, "They came for a while but then they petered out."

The provider had failed to ensure people's communication needs were met. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

●There was a complaints policy and procedures in place. The provider kept a log of complaints received. There were few of these, however we saw that complaints were addressed appropriately and in a timely manner.

End of life care and support

● Most staff didn't receive end of life training. Care plans did not contain any information about people's end of life wishes. However, the deputy manager was able to show us evidence that people were consulted and basic information about their wishes was recorded elsewhere. One person had stated they wanted to be cremated and had chosen which music they wanted playing during the service.

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider had monitoring systems in place, and there were regular spot checks undertaken. However, these were ineffective as they had failed to identify the issues we found during our inspection.
- Audits had failed to identify that care and support plans and risk assessments did not always provide staff with the necessary information to support people safely. Checks of the environment, furniture and equipment had not identified areas which required repair, improvement or servicing. When staff had identified this, action had not been taken to address this in a timely way.
- Systems to monitor the service had failed to identify that the environment and activities available were unsuitable for people's needs in particular those who were living with dementia.
- Monitoring systems had failed to identify that people were not always treated with dignity and respect, and their communication needs were not always met.
- Monitoring systems had failed to identify significant safety concerns which put people at risk of avoidable harm, such as staff not following health and safety, infection control and fire procedures.
- The provider and registered manager did not always ensure that suitable arrangements were made to cover the home in their absence. They had not always ensured the person covering was prepared and qualified to undertake this role.

Continuous learning and improving care

- It was not always clear where learning from incidents and accidents had taken place. One person who had a high number of falls had not been provided with a sensor mat to alert staff and prevent further falls, as agreed in November 2019. This meant the risk of avoidable falls remained high. This showed the provider had failed to learn from this and had not improved the safety for this person. The provider's monitoring systems had failed to identify this.

The provider did not have effective arrangements to assess, monitor and improve the quality of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

characteristics

● Meetings for people who used the service were irregular. One staff member told us, "I know there has not been one at least since October last year." However, after the inspection, the registered manager told us they spent time with individuals to discuss their care.

● People were consulted via pictorial quality questionnaires. We viewed these and saw a good level of satisfaction.

● Staff meetings were not always regular. The last meeting had happened in November 2019 and none had taken place since. However, staff told us they were always able to speak with the management team and felt supported.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

●The registered manager understood the importance to be honest and open when mistakes were made, or incidents happened, and to offer an apology. They reported incidents to the relevant agencies and dealt with complaints in line with their policies and procedures.

Working in partnership with others

● Staff worked with a variety of professionals including GPs and social workers to support them in meeting people's needs. One healthcare professional told us they found the staff responsive to people's needs and said, "The staff that I came into contact were always respectful, caring and knowledgeable about my client's wishes, needs and habits.

● Professionals stated they found the registered manager approachable. One social care professional told us, "I did find in my dealings with the care home that the manager was always professional, caring, responsive and thorough."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person did not do everything reasonably practicable to make sure that people who used the service received person centred care and treatment that was appropriate, met their needs and reflected their personal preferences. Regulation 9 (1) (a) (b) (c) (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered person did not always ensure people were treated with dignity and respect Regulation 10 (1) (2) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person did not always ensure sufficient numbers of qualified, competent, skilled and experienced persons were deployed in order to meet the needs of people who used the service Regulation 18 (1)