The Fremantle Trust

Carey Lodge

Inspection report

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Date of inspection visit:
27 July 2021
03 August 2021

Date of publication:
10 December 2021

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Carey Lodge is a residential care home providing personal care and support for up to 75 older people some of whom are living with dementia. At the time of the inspection 52 people lived at the home. People's accommodation is located in six separate areas referred to as 'houses', located over three floors. Each house has individual bedrooms and communal dinning and lounge areas. The home had many seating options on each floor.

People's experience of using this service and what we found
People were not routinely and consistently supported by a service that was well-led. People were placed at ongoing risk of harm as systems and processes were not in place to assess, mitigate and manage risk.
On day one of the inspection we had major concerns about people's safety if a fire or emergency occurred. We found the manager and other staff could not be confident about how many people were in the building. We found records ranged from 45 to 56. An inspector was escorted around the building to carry out a physical head count of people so we could be confident who was in the building. Equipment which should be used in the event of a fire was stored inappropriately by the front door, not where is was needed on first and second floors. We found the service was ill equipped to deal with a fire, no fire grab bags were readily available. Due to the level of concern we had we made an urgent referral to Buckinghamshire Fire and Rescue Service. The fire service visited the care home following our referral. We have since been informed 11 immediate actions were identified and the fire service will be re-visiting to ensure those actions have been carried out.

People were not protected from the risk of infection. We found the home had many areas which needed cleaning or correct storage of hazardous waste. We routinely observed staff not following government guidance on the use of face masks, which put people at risk of contracting COVID-19.

We found people at risk of malnutrition and dehydration were not routinely supported to ensure their health did not deteriorate. We found people had routinely gone in excess of 12 hours without being offered any fluids. One person's records showed they had gone 17 hours and 10 mins with no offer of a drink.

Risk assessments were completed by staff who had not received training on how to do this accurately. We found risk assessments were incomplete and failed to assess the level of harm to people. One person who was at risk of choking needed a soft diet and struggled to swallow a tablet had a risk assessment in place dated 23 July 2020. This had not been updated to reflect their current needs. One person had a sore on their back, there was no accurate risk assessment in place to prevent further deterioration in their skin.

People were not consistently supported with their prescribed medicines. Staff did not routinely have access to additional guidance on when, how and why they should administer medicine for occasional use. This put people at risk of receiving more or less than was needed to support them safely.

Records relating to people's care and treatment were not routinely stored securely or accurate and did not always represent a complete and contemporaneous record of support provided. On day one we found confidential notes were laying on a table in a communal area. This could have been read by any unauthorised person.

People were supported by staff who had been recruited safely, but they had not always been offered or undertaken training suitable to their role. People and staff told us, and we observed the deployment of staff could have been improved. We found times when no staff member was present, and people were observed to be sitting alone in a lounge area.

The service had received complaints, these had not always been handled in line with the provider's policy and we found some had not been acknowledged or responded to.

People were not routinely supported by staff who respected their dignity, we found staff routinely entered people's rooms without knocking.

Systems either were not in place or were ineffective to ensure action was taken to improve people's experience as a result of feedback. The provider had failed to ensure improvements had been made since our last inspection.

People were not routinely supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. We have made a recommendation in the report to ensure people were routinely supported in line with the Mental Capacity Act 2005.

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 requires improvement (published 24 February 2020) and there were multiple breaches of regulations. The provider completed an action plan after the last comprehensive 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
We carried out an unannounced comprehensive inspection of this service on 8 and 9 January 2020. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment, compliance with the Mental Capacity Act 2005 and good governance. We issued a warning notice to ensure improvements were made. We carried out a targeted inspection on 28 and 29 October to check if the warning notice had been met. We found the provider was still in breach of regulations in the areas of safe care and treatment and good governance. Following the targeted inspection, a decision was made not to escalate any enforcement. We took into account the impact of the COVID 19 pandemic.

We undertook this focused inspection to check what action had been made since the targeted inspection and to confirm the service now met legal requirements. This report only covers our findings in relation to the key questions Safe, Effective and Well-led.

The inspection was prompted in part due to concerns received about how well-led the service was and risks posed to people.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvements. Please see the Safe, Effective and Well-led sections of this full report.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to management of risks, health and safety, deployment and support for staff, meeting people's nutrition and hydration needs, management of complaints, good governance and meeting the requirements of notifying CQC of certain events.

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

Following the concerns we raised about the poor quality of care provided by The Fremantle Trust at Carey Lodge. The provider, The Fremantle Trust made a decision to close the care home. Carey Lodge has been removed as a registered care home.

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 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 well-led? The service was not well-led. Details are in our well-Led findings below	**Inadequate**

Carey Lodge

Detailed findings

Background to this inspection

The inspection
We carried out this focused 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.

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

Inspection team
The inspection was carried out by three inspectors on day one and two inspectors and an inspection manager on day two. On day one the inspection the team was joined by an Expert by Experience, the day after the first day of the inspection another Expert by Experience made telephone calls to people's relatives. 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
Carey Lodge 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 did not have a manager registered with the Care Quality Commission. The provider was 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 the last inspection. We sought feedback

from the local authority. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We used all of this information to plan our inspection.

During the inspection
We spoke with 14 people during the inspection and contacted six relatives by telephone, to seek their views about standards of care. We spoke with 16 members of staff including the manager, operations manager two deputy managers, team leaders, support staff and staff responsible for activities and administration staff. We spoke with the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke with the chief executive who had visited the service to meet with us on day two of the inspection.

We reviewed a range of records whilst on site and requested some to be sent to us. This included 25 people's care records, some in part to look at specific areas. We looked at 14 people's medicines records. We looked at five staff files in relation to recruitment and staff supervision. We looked at a range of records relating to the management of the service, these included, health and safety records related to fire checks and certificates for gas and electrical safety and incident reports. We looked at staffing rotas, staff allocation and handover records, complaints, and management audits carried out.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at records requested and sent to us from the service. We continued to seek feedback from professionals who regularly visit the service and staff. We received feedback from 15 staff who had responded to our requests for feedback.

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 comprehensive 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.

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. We found people continued to be put at risk of avoidable harm as potential risks to people were not recognised or mitigated. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had still not been made at this inspection and the provider was still in breach of Regulation 12

● People were not routinely and effectively protected from potential avoidable harm. We found the provider had not ensured they had done all that was reasonably practicable to mitigate risks. Risk assessments had not always been completed when required or lacked accurate detail to mitigate harm to people.
● People's risk of malnutrition had not been assessed accurately which placed them at risk of not receiving sufficient nutritional support to maintain a healthy weight. The service used a nationally recognised assessment tool called 'Malnutrition Universal Screening Tool' (MUST). We found this assessment was routinely completed incorrectly. The MUST assessment can result in a score of zero, one or two, each score indicated the level of risk, two being a high risk and zero being identified as a low risk of malnutrition. One person's MUST record showed a routine score of four. We found another person's score had been routinely recorded as three or four.
● People who were identified at risk of dehydration did not routinely have their needs met. We found records indicated people had not been offered drinks regularly to ensure they were well hydrated. One person's food and fluid care plan dated 8 June 2021 stated "staff to encourage [name of person] to drink throughout the day and when awake at night" and "Staff to fill out a fluid chart daily to make sure [name of person] is kept hydrated. Records for July 2021 showed the person routinely went in excess of 12 hours without any record of fluids being offered or taken on 10 occasions this time exceeded 14 hours. In the 24-hour period from 13 July 2021 to 14 July 2021 records showed they had gone 17 hours and 10 mins without being offered a drink. Another person who was cared for in bed had routinely been left for over 12 hours without being offered a drink. This placed them at risk of dehydration as staff could not determine whether people had received enough to drink. We observed people throughout our inspection with drinks untouched beside them.
● People were not consistently supported to reach their daily fluid intake targets. Care plans showed in part people's daily intake of fluid target. We found one person had a daily fluid target of 1950 millilitres. In the month of July 2021 this target had only been reached on nine of the 31 days of the month. The lowest

recorded daily intake was 840 millilitres on 24 July 2021. Another person had a care plan in place dated 19 June 2021 which stated "if [name of person] shows signs of frequent pain in stomach, is not eating and drinking or is not opening her bowels she would need to go back into hospital for investigation". We looked at their fluid recording charts for July 2021. They had a target daily fluid intake of 1248 millilitres. We found they had reached this target on 7 days of the 31 days of the month. The lowest daily intake recorded was 550 millilitres which was on 15 July 2021. We found no action had been taken to highlight the person's poor fluid intake. This put them at risk of ill-health. We told the provider about our concerns about people. Following our feedback the provider informed us they had made referrals to health care professionals to check on people's well-being and health.

● People who were at risk of pressure damage did not routinely have risk assessments in place or had action taken to prevent a deterioration in their skin integrity. On 22 July 2021 staff had recorded in one person's daily notes "sore on her back". This was first reported to the district nurses (DN) the same day. This sore was in addition to a skin tear which was already being treated by the DN team. We checked if the person had a risk assessment in place. The service used a nationally recognised assessment tool called Waterlow. A Waterlow assessment was in place dated 16 June 2021. This recorded the person's skin was dry and intact. The Waterlow assessment had not been updated to reflect their sore back. In addition, we found a skin integrity care plan in their file which was blank. When we were looking at the care plans a team leader advised us. "I have not updated them yet." We also found people had not been supported to move position in line with the stipulated time frames to reduce the risk of any deterioration in their skin health.

● People who were at risk of choking either were not routinely assessed by staff for this risk or when it had been assessed, documents showed contradictory information. Food and fluid care plans and risk assessments failed to reference the International Dysphagia Diet Standardisation Initiative (IDDSI) texture or thickness of foods and liquids. One person had been seen by a speech and language therapist who advised staff should "continue to thicken all drinks to a level 2 'Mildly thick' consistency (2 Scoops Resource Thicken Up Clear per 200ml)". We looked at their care plan and it stated, "two flat scoops to be added to 1200 mls jug", this had the potential to put the person at risk of choking as it would make the drink too thin.

● People who had medical conditions and were prescribed medicines which had the potential to cause harm were not routinely protected. We found not everyone who was prescribed and administered anticoagulant medicine had a risk assessment in place. This medicine had the potential to cause internal and external bleeding.

● We found risk assessments were not routinely followed by staff. One person's risk assessment stated they required two staff to support them whilst walking. On three occasions we observed only one staff member was walking with them. This put the person at risk of falling. Staff told us they did not always know people's needs as they had not worked with them previously. On day two one member of staff was working for the first time on one of the 'houses'.

People were placed at continued risk of harm due to poor risk management procedures in place. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were not adequately protected from the risk of fire.

● Folders containing personal emergency evacuation plans had not been kept up date, to reflect who was on the premises and the support they would require in an emergency.

● Records and other systems at the home gave contradictory information about how many people were being cared for at Carey Lodge. This ranged from 45 to 56. An inspector needed to conduct a physical head count with a member of staff, to obtain an accurate figure. We expect care homes to know how many people were on the premises in the event of an emergency and for evacuation purposes.

● Records of fire drills were inadequate. They only recorded which staff were present, the date and time.

There was no information recorded under headings on the form about any issues identified, how long the drill took, availability of equipment and areas for improvement.
● Equipment to assist in emergencies (evacuation mats) was stored in a hamper by the front door, rather than located around the building where it would be needed. This was rectified on the second day of our inspection.
● There was no 'grab bag' for use in emergency situations, to assist staff in dealing with an evacuation of the premises. The operations manager told us a grab bag should be located in the entrance hall by the front door, but there was nothing there. The manager said they were obtaining some items to put together and showed us a backpack that had been purchased. This was reached by clambering over boxes and cleaning products in the housekeeping office. The backpack contained very little to assist in an emergency. For example, there were no copies of personal emergency evacuation plans, emergency contact numbers, staff contact numbers or next of kin details. The provider made some improvements by the end of the first day of the inspection. There were still some items that needed to be added when we checked on the second day of our visit. For example, the business continuity plan and contact numbers had not been added.

This was a breach of Regulation 12 (Safe Care and Treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the provider had not taken adequate measures to assess and mitigate the risks from fire.

● We asked the provider to ensure all PEEP's were reviewed without delay. We received confirmation this had been completed prior to our second day at the service.
● Staff responded well to an emergency during the second day of the inspection, when a major water leak occurred on one of the upper floors. People were moved to other parts of the building whilst work took place to secure water and electrical supplies in that area.
● Equipment was serviced to ensure it was in safe working order. For example, there were weekly tests of the fire alarm, sprinkler system and fire extinguishers.
● The premises were maintained well. Checks were made of water, gas and electrical supplies.

Using medicines safely

At our last inspection the provider had failed to manage people's medicines safely. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had still not been made at this inspection and the provider was still in breach of Regulation 12

● People were not routinely and consistently safely supported with their prescribed medicines. We looked at the use of medicines at the home and found they were not managed safety.
● Several people had one or more medicines prescribed as 'when required' (PRN). However, we found PRN protocols were not always in place. Therefore, we could not be assured that staff were administering PRN medicines appropriately. When protocols were in place, they were not always person specific. Therefore, we were not assured that staff would consistently assess the person's need for PRN medicines.
● We found people were prescribed variable doses of PRN medicines to help manage their levels of distress or anxiety. However, there were no PRN protocols in place for these medicines. Stock balances indicated the medicines had been administered at both higher and lower doses inconsistently on a regular basis without seeking specialist advise. Therefore, staff did not have enough information to support them to administer variable doses of PRN medicines as intended by the prescriber.

● We found people did not routinely have a medicines care plan in place and staff told us they were still in the process of documenting people's care plans. Where care plans were in place, they did not always have person specific information about people's medicines to guide staff on how to support people safely.

We found no evidence that people had been harmed, however medicines were not always managed safely. This was an ongoing breach of Regulation 12 (Safe Care and Treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Where people had been prescribed PRN medicines, staff did not always record this on the medicines administration record (MAR). For example, staff did not always record the reason for administering the PRN, they did not always record the dose administered for variable doses or the outcome and whether the medicine was effective. Therefore, we could not be assured that PRN medicines were being administered as prescribed and having their desired therapeutic effective.
● Staff told us they had learnt from previous incidences, including ordering medicines in a timely way to prevent people from missing any doses of medicines. However, on the day of inspection we found one person's blood pressure medicine had run out, resulting in them missing their medicines. Staff had failed to take any action prior to the missed dose. Staff were not following the providers medicines ordering policy.
● Generic risk assessments for paraffin-based creams were carried out. However, these were not personalised and therefore were not a true assessment of the potential risk to each person.

This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as medicine records were not always accurate and complete.

Preventing and controlling infection
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. We found areas of the home, such as toilets, that had not been kept in a clean and hygienic condition. Packets of incontinence pads were stored on toilet floors and on the floor in a sluice room. We also saw incontinence pads had been taken out of packs and placed on top of toilet cisterns and, in one case, a clinical waste disposal bin. We found a used lateral flow test on the floor in one of the offices. We saw packs of toilet paper stored on the stained shelves of two trolleys used by housekeeping staff.
● We were not assured that the provider was using personal protective equipment (PPE) effectively and safely. Throughout the inspection, we saw care workers and managers not wearing masks properly, exposing their nose or wearing the mask under their chin. A manager removed their mask in front of inspectors and disposed of it in a communal waste bin, not a clinical waste bin.
● We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed. We saw a member of staff was wearing false nails, contrary to good hand hygiene practices. There were no handwash items or alcohol gel available in one of the sluice rooms. Records showed a member of staff had turned up to work earlier in July, when they had a stomach upset. As well as being at work when it was unsafe to do so, the record showed they prepared breakfast for people without the use of PPE. This was contrary to safe food handling practices.

The provider had not taken adequate measures to prevent and control the spread of infection. This was a breach of Regulation 12 (Safe Care and Treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were somewhat assured that the provider was preventing visitors from catching and spreading infections. Visitors were expected to provide proof of a lateral flow test carried out that day or to undertake one on arrival. There was a procedure for temperature checks to be carried out on visitors before they

entered the building. We could see a log was kept of temperature checks. However, one of the inspection team, who staff had not met before, was let into the home without any checks being undertaken.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider's infection prevention and control policy was up to date.
● Senior managers and the provider's human resources department were encouraging all staff to receive both doses of vaccination against the coronavirus, in light of the government's announcement to make this a requirement of deployment for care workers (unless they are exempt).

Staffing and recruitment
● People were not routinely supported by staff who were deployed in a manner which supported safe care.
● Staffing rotas were in place. Care workers were assigned to work in designated parts of the building. Team leaders and senior staff were also on duty to co-ordinate shifts and help ensure people received the care they required.
● We received mixed feedback from people about staffing levels. Negative comments included, "There are plenty of staff in…today. Some days they are very short. I know they (managers) phone up girls when they are on holiday if they are really short, they shouldn't do that" and "You don't really get to know most of the carers, I don't really think there are enough of them". Relatives told us "They're short staffed" and "There's a lack of staff". Two people gave more positive feedback. Comments included, "I think that there are enough carers, just about right I would say" and "If I do press my bell they come along quite quickly".
● Staff comments included "I think the numbers of care staff are short sometimes. The seniors will help sometimes but not always. It is difficult with no support and you have a number of one to ones to do." "The staffing level isn't good. This has been an on-going problem for as long as I can remember and I'm sure is a problem in many other homes…It becomes very stressful for the staff and the residents when you don't have the staff to even give them their basic needs. I feel like there is always plenty of 'management staff' in the building but low levels of actual 'on house' staff." Another staff member told us "Staffing levels can be difficult, as we have three people who need help from two staff", "Staffing levels can be improved especially for doubles (people who required two staff), in the morning and evening it is more challenging".
● We observed the morning routine in different parts of the home. Staff were kept busy assisting people to get up and have breakfast and supporting other people who showed signs of distressed behaviour. We could hear staff communicating amongst each other to check what support had been provided to people.
● We observed there were occasions throughout the inspection when no staff were present in communal areas where people were seated. This meant people who were at risk of falling may not have been supported in a timely manner.
● A relative who had recently complained about their relative's care had commented "During the time we were there members of the team were discussing how short staffed they were and how potentially someone was going to have to do an all-nighter." The same relative stated "in all honesty it was like people were running around in circles and nothing actually happening."

Staff were not deployed in a manner which promoted person centred care. This was a breach of Regulation 18 (Staffing) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were supported by staff who had been recruited using robust processes.
● Required recruitment checks were carried out when prospective staff applied to work at the service. This included obtaining written references and verifying identification.
● A check was carried out for criminal convictions and inclusion on lists of people who would be unsuitable to work with those at risk.

● People's comments about staffing included "The staff are lovely. They try to get done the things you ask them to do".

Learning lessons when things go wrong

● People were not routinely protected from avoidable harm as opportunities to learn lessons when things went wrong were not always carried out. Accidents and incidents were recorded. However, there was a lack of managerial and provider oversight of these. We asked the manager what action they had taken to identify any trends in accidents or incidents. They told us no analysis of falls had been carried out. We asked the provider again if any analysis of falls had been carried out. On the 29 July 2021,the nominated individual sent us a falls analysis which the manager stated on 27 July 2021 was not in place. We found there was confusion about what action had been carried out to identify trends in falls.

● We found accidents and incident reports were stored in various places. On both days of the inspection we observed piles of incident reports in management offices. There did not appear to be any order to the storage of completed forms, and no-one in a senior position had oversight of events which had occurred.

The provider had failed to evaluate and improve their practice to promote people's safety. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● People were supported by staff who had received training on how to recognise and report abuse.

● People told us they felt safe in the service. Comments included, "Yes, I do feel safe, I do, I couldn't think of changing anything for the better", "I am perfectly happy living here, thank you I have no complaints at all" and "It does feel safe here though".

● Relatives told us they were happy with the care their family member received. Comments included, "The staff seem very caring of her. They know her. She's very pleased to be known. Before where she was, she was just a lump. Here they know her and they know her needs", "It's very nice. It's made a huge difference to [relative's] quality of life. Her medication is taken care of, she's properly fed and she's happy", "She was very, very unhappy before she moved in. She was fed up and miserable. But now her quality of life's better. They are kind to her" and "I took a photo of her the day before she moved in and she looked so miserable. Now she looks like a different person. It's the round-the-clock care."

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 comprehensive inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

At the previous comprehensive inspection in January 2020, we recommended the provider consulted recognised sources of guidance to ensure that all staff holding line management responsibility had received appropriate training.

At this inspection we found ongoing concerns about staff training and their skills and understanding to complete certain tasks and assessments.

- People were not routinely supported by staff who had received training to equip them with the skills to assess risks to people. Training records showed staff had not fully acquired the skills they needed to meet the needs of older people.
- We saw a range of courses had been attended. Some of these were considered mandatory by the provider, others were marked as relevant for personal development. Records showed several courses had been completed but there were gaps in some areas required by the provider for the person's role. For example, in basic life support, data protection, communication, end of life care, person-centred care and coping with loss and bereavement.
- At least 13 support staff or senior staff had not completed training in diabetes awareness and 17 in dysphagia. Dysphagia is the medical term for swallowing difficulties. It would be important for staff to be skilled in these areas to meet the needs of the people they cared for.
- A course was available on nutrition and hydration (marked as for personal development rather than mandatory) but this had not been completed by many staff; we noted 44 staff had not done it. This was a concern, given the importance of nutrition and hydration in keeping older people well. Only two senior staff had completed training on the malnutrition universal screening tool (MUST), to be able to assess and identify the risk to people.
- The least completed training was fire drill attendance, which had not been undertaken by 46 staff. This included all of the night staff.
- Records showed one team leader and three senior care workers had completed training on supervising staff. There was no information about other staff in supervisory roles.
- Records of supervision showed a mixed picture of support provided to staff. One member of staff had received supervision a month after they started, another six months after starting. Another member of staff had not been supervised this calendar year, whilst a further worker had not been supervised since October 2020. One person in the sample we checked had been supervised twice this year and received an appraisal

of their work. Two other workers in the sample had been at the service long enough to require annual appraisals (development reviews). Records showed one worker had been appraised in June 2019, the other in December 2020. This showed inconsistency in the support provided to staff.

● We noted instances where staff had supported people during episodes of physical and verbal aggression. For example, ten records had been completed by the same care worker where they had been shouted at, sworn at, pushed over, punched and slapped in the face. There was no information on the incident forms about any debriefing or support given to staff. When we raised this with a manager, we were told information would be recorded on the handover records. Nothing was written on these. We could not be confident staff had been supported on these occasions.

The provider had not ensured staff had received the support and training necessary to enable them to carry out the duties they are employed to perform. This was a breach of Regulation 18 (Staffing) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● People's nutritional needs were not always effectively met.

● We saw people's nutrition and hydration needs were identified in their care plans. Malnutrition universal screening tools (MUST) had been completed to assess and identify risks. We saw these had not always been completed correctly or kept under regular review.

● For example, in one file the MUST identified a high risk up to 13 April 2021 and had not been evaluated since. The tool advised weighing people at high risk on a weekly basis. Records showed they had only been weighed twice in June this year and once in July. The last recorded weight on 1 July 2021 showed the person had started to lose weight again. There was no record of seeking advice from the GP or referral to a dietitian in the health intervention records.

● Two relatives had some concerns as their family members were losing weight. When asked if the home had discussed this with them, one of the relatives said, "They've never discussed [name of person] with me at all." Another relative told us "I've got some concerns on the dietary side. They should make decisions for her. She's losing weight. It needs improvement, it needs monitoring."

● People did not consistently receive the support they needed at mealtimes. A care worker asked one person if they would like help with their meal, which they did. The care worker sat beside the person and provided some support but left after a couple of minutes, saying "You might be able to do it." The care worker only returned to collect the uneaten lunch. Another person was cared for in bed and had the meal brought to them. They were left alone and unassisted. After just ten minutes a care worker returned and removed the untouched main course. A pudding was then provided and they only managed a couple of mouthfuls. Calorie intake would have been very low in these instances, contributing to weight loss.

The provider had not taken adequate measures to ensure people's nutritional and hydration needs were met. This was a breach of Regulation 14 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We saw evidence of 'kitchen information' forms, to advise catering staff of people's likes, dislikes, special requirements and allergies.

● Meal times were unrushed. People could eat their meals in the dining rooms, lounges or in their rooms. Staff asked people if they were enjoying their meal (they were).

● Comments from people included "The food is generally good. The menu is a bit monotonous sometimes, you get the same thing over and over, it seems it is always apple crumble. The only thing I would like, if I could, would be more variety in the food." "All the food is very good and the staff are good. On the whole we accept the food that we have but there is a choice if we don't like something. There is always plenty of it, the

portions are about right." Relatives spoke positively about meals. One said the home was reviewing menus so there was more choice.

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

At the previous comprehensive inspection in January 2020, we found ongoing concerns about the how the service applied the Mental Capacity Act 2005 (MCA). We found the service was in breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found some improvements had been made. However, we had ongoing concerns about people being consistently supported in line with the MCA. We have made a recommendation about this.

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.

● People were not routinely and consistently supported in line with the code of practice of the MCA. We found mixed practises and inconsistent record-keeping.
● We found mental capacity assessments detailed the decision which was being made. These ranged from people accepting care to people residing behind a locked door. We found records showed if the person lacked capacity to make the decision a best interest process was followed. However, we found records did not routinely show the full discussion held with third parties. This is important to ensure decisions were made in people's best interests.
● The local authority best interest assessors told us they found mental capacity assessments had not always been conducted when needed. They told us they had added a condition to the authorised DOLS for mental capacity assessments to be completed by staff at the care home.

We recommend the provider seeks guidance from a reputable source about ensuring the MCA is applied when required and assessments are completed in line with the code of practice.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People were referred to external healthcare providers when required. The service had support from two local GP practices, and had access to an online video calling medical helpline (Telemeds). This was used when people had shown a deterioration in their health.
● One person had been recently reviewed by the community learning disability team following concerns

about their ability to maintain their sitting posture. We found other people had been seen by speech and language therapy, physiotherapy and district nursing staff.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Adapting service, design, decoration to meet people's needs

● Prior to being admitted to the care home, people had their needs assessed. Assessments identified any individual needs which related to protected characteristics identified in the Equality Act 2010. For instance, preferred language, faith, religion, sexuality and cultural considerations.

● People lived in a home which was appropriately adapted and designed to meet their needs. The building was divided into six units or 'houses,' each with their own lounge, dining room and bathrooms. Each person had their own room with en-suite facilities. People could personalise their rooms.

● Equipment such as adapted baths, hoists and grab rails were provided. Corridors were fitted with handrails which contained sensory nodules, to assist people with visual impairments find their way around safely. There was level access throughout the building. A passenger lift provided access to all floors.

●There were quiet areas for people to use if they wished to be on their own. These were themed and provided areas of interest. The home had a shared lounge where activities were held. There was a kitchen area adjacent to it where people could make drinks. The home had an attractive, well-kept garden, with plenty of seating, tables and a marquee. People were seen assisting activity staff in the garden's upkeep.

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 comprehensive 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.

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

At our last comprehensive inspection the provider had failed to ensure that systems were robust enough to demonstrate safety was effectively monitored and managed and we were not assured that there was effective management oversight at both location and provider level. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had still not been made at this inspection and the provider was still in breach of Regulation 17.

● People were living in a home which was not well-led. There was a lack of effective managerial oversight within the home and from the registered provider. There was no registered manager in post. On day one of the inspection there was a manager in post and onsite. On day two of the inspection they were absent from the home. We have since been informed they will not be returning to the home. The provider informed us after the inspection of the interim arrangements for management cover at the service.
● We found people's records were either incomplete, inaccurate or contradictory. There was no order to people's records. We found loose papers in filing cabinets and a lack of contemporaneous records in relation to decisions about people's support. Poor record keeping increased the risk of people not receiving safe care.
● Risk assessments were incomplete and did not adequately assess potential harm to people. One person's turning charts failed to identify if their skin was intact or if equipment used was working. Another person's nutritional risk score was rated incorrectly and not in line with the national guidance. We found food and fluid charts were routinely missing times of drinks offered, a daily fluid target to be reached and contained incorrect totalling of fluid taken.
● We requested a number of documents to be sent to us after the inspection. We made the request on 4 August 2021. Documents sent to us on 5 August 2021, had a completion date of the 4 August 2021. We found the sent items contradicted other records we had gathered while onsite on 3 August 2021. For instance, one person's weekly weight and nutrition risk assessment we checked on 3 August 2021 stated they had been weighed on 1 August 2021 and a weight of 37.2 kilograms had been recorded. Records sent to us by the

nominated individual on 5 August 2021 stated the same person had been weighed on 4 August 2021 a weight of 40.1 kilograms had been recorded. Another document sent to us by the nominated individual on 5 August 2021 for a person's mobility was dated 4 August 2021. Throughout the document the wrong person's name was used. We asked the nominated individual if they had provided accurate information to us. They replied to us on 9 August 2021 "I can confirm that to my knowledge, the information I have sent is accurate and up to date." We found records did not routinely reflect people's needs or were accurate and up to date.

● We found there was no standard audit schedule to ensure care plans were kept up to date and accurate. We found old care plans stated they had been reviewed and "reviewed, no changes" had been recorded, however, we found a new document had been written the same day. This was the case for one person's mobility care plan. We reviewed the two documents and they differed in content. This meant staff did not have access to the most up to date and accurate information about people's care needs.

● Senior management oversight of the service failed to pick up the issues we found. Audits carried out were ineffective and did not drive improvements in the service. For instance, a manager's daily walk round and safety check had been carried out on 26 July 2021, the day before our first visit to the service. It scored the service as 98 percent compliant. It noted the home was clean and tidy, clinical waste was stored correctly, accidents and safeguarding had been added to the provider's electronic system. This audit had been completed by the manager. However, this did not reflect what we found less than 24 hours later.

● Senior managers' visits to the home conducted by the operations manager identified some actions required. However, we found previous actions were not routinely followed up to ensure they had been completed. On 6 July 2021 one action identified was to ensure a risk assessment was put in place for a person who was at risk of fire, due to their hoarding tendencies. On 3 August 2021 we checked the person's records. No risk assessment was in place.

There was a continued lack of managerial oversight in the service both at the home and at provider level. This was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service has been in breach of this regulation since the November 2018 inspection.

● Providers and registered managers are required to notify us of certain incidents or events which have occurred during, or as a result of, the provision of care and support to people. One notifiable event is when there has been an allegation of abuse. We found one complaint had been received by the service on 19 July 2021. It referred to a person being left unattended outside in extreme heat. The person had become unwell and needed medical attention. This would have met the threshold for alleged neglect. No referral was made to the local authority and no notification was made to CQC.

● Another event which requires a notification to CQC is when a serious injury has occurred. One person had fallen on 2 June 2021 and had hit their head. The person was at risk of internal bleeding as they took an anticoagulant medicine on a daily basis. Following the fall, they attended hospital for a head scan. No notification had been made to CQC.

● The local safeguarding authority had advised us they were undertaking a safeguarding enquiry. We checked our records and we had not been notified of this. We contacted the manager and nominated individual on 18 June 2021. They sent a statutory notification to us on 24 June 2021. This meant there was a delay in the service meeting the requirements of the regulation.

● Following the inspection the provider made retrospective notifications to us.

This was a breach of Regulation 18 (Notification of Other Incidents) of the Care Quality Commission (Registration) Regulations 2009.

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

outcomes for people; Continuous learning and improving care

● People, their relatives and staff did not consistently have confidence in the management team to provide a good service. Comments included "The new manager, he's trying to do too much too soon", "I believe the staff are not told that new residents are in, the first thing they know is when they see them", "There have been lots of changes and the home has had a tough period" and "There have been lots of management changes." A relative commented "I would want stability with the staff and the whole structure, stability with plan…There's no clear lines of responsibility or accountability or clarity on how the home operates". Another described the management as "chaotic" and "It's woolly".

● The provider had not responded to our previous concerns. We issued a warning notice following repeated breaches. When we followed these up in October 2020, we found they had not been met. Although the provider had put an action plan in place to make improvements, at this inspection we found the oversight, stability and ability to ensure people received safe care and treatment had further deteriorated. We found the service to be in multiple breaches of the regulations.

● We requested feedback from staff; this was not responded to in a timely manner. When staff did provide feedback, they told us the manager had "Never introduced himself and there is never any thanks from him." Other comments from staff included "He is not approachable", "Treats us like we are nothing" and "They have no time for carers".

● We found information was not readily available. We requested additional information from the provider and gave clear deadlines for when we expected to receive information. We found none of the timeframes were met and we often had to return to the provider and ask for missing information to be provided. We gave this feedback to the chief executive who visited the service on day two of our inspection. However, we found timeframes continued to be missed.

The provider failed to act on feedback and ensure there were effective systems in place to manage the service. This was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were not routinely supported by staff who demonstrated dignity towards them. We found staff routinely wore face masks incorrectly which placed people at potential harm from infection. We observed staff entering rooms without knocking and removing uneaten meals without any encouragement. We observed staff asking for puddings from a lunchtime meal to be left for them to eat later, we noted the name of a staff member had put on a label on pudding bowl. We observed one person was asked by staff "Do you want to go back to your room, do you want to take your napkin with you". The person replied "No, I usually fold it and leave it here". The staff member snatched the napkin from the person and began to fold it. The person commented "Why did I open my mouth, I wish I hadn't bothered".

● People's wishes were not always recorded or documented correctly to ensure they would be met. One person's 'End of life' care plan said there was no DNACPR in place. However, they had a DNACPR in place at the front of their file. The DNACPR decision was made on 2 August 2020, the care plan was written on 2 June 2021.

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

● People's complaints were not consistently managed effectively.

● We requested information about the number of complaints received since October 2020, with evidence of the complaint, how it had been handled and the outcome. We received a spreadsheet with information about nine complaints. Five of these did not have a date to indicate if they had been acknowledged.

● There were only two instances where a date had been recorded of when the complaint had been resolved or a conclusion reached.

● Four complaints had been upheld and a further one was partially upheld. In two instances there was no information about the actions taken in response to these complaints.
● Three more recent complaints had no information under 'current status'; one of these related to a family being "extremely concerned about their (relative's) welfare and well-being". From the records provided to us, we were unable to see whether complaints had been handled effectively.

This was a breach of Regulation 16 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the provider was unable to demonstrate they had an effective system in place to record, handle and respond to complaints.

● People had been able to keep in touch with the service during the pandemic.
● A visitor told us "There is a Family and Relatives Forum operating here, online. There are a dozen of us and we have some good chats with each other. The home's new manager has joined us for two or three of them."
● Other people told us about on-line meetings/calls which had been set up. One said "There are Zoom calls, which is good. Other relatives speak up, there's common themes. The communication in the home is better now." Another relative commented "They're really good (on-line meetings). You can ask anything and they've got an answer or they go and find out."
● Information was shared with people who use the service in residents' meetings. A service user survey was carried out in January/February 2021, to seek people's views. Reponses were positive.
● Regular staff and management meetings were held at the home, to discuss practice and look at ways of making improvements.

Working in partnership with others
● The service worked with external healthcare professionals. Two local GPs visited the home on a regular basis. In addition, the community district nurses had an office base within the care home.
● During the height of the pandemic, a group of local people had provided scrubs to staff. The service had recently held their annual scooter meet up. Although some external entertainers had been unable to visit the home during the last year. A member of staff told us "The Music Van has come around a couple of times and stops in the car park… Residents watch the singers from the balconies".

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 18 Registration Regulations 2009 Notifications of other incidents How the regulation was not being met The provider failed to ensure the CQC was notified of all reportable events. Regulation 18 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met The provider failed to mitigate risk and potential harm to people. We were not routinely supported safely with their prescribed medicines. People were put at risk of harm from fire and possible infection. Regulation 12 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs How the regulation was not being met The provider failed to ensure people's nutritional and hydration needs were routinely met. Regulation 14 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints How the regulation was not being met The provider failed to ensure complaints were handled in line with their policy, acknowledged and investigated Regulation 16 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance How the regulation was not being met The provider failed to ensure effective systems were in place to ensure people's needs were met and records were accurate and contemporaneous. Regulation 17 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing How the regulation was not being met The provider failed to ensure staff were deployed to ensure people's needs were met. Staff did not routinely have training suitable to their role. Regulation 18 (1) (2)