Park Homes (UK) Limited

Norman Hudson Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Norman Hudson Care Home is registered to provide residential and nursing care for up to 42 people. At the time of the inspection there were 27 people living in the home, the majority of whom were living with dementia. The home is situated across 3 floors, with communal areas on the ground floor.

People's experience of using this service and what we found
We were not assured medicines were administered as prescribed and robust recording was not in place. Medication running balances did not always match stock held, 'as required' medicines were missing protocols and the medication fridge temperature was operating outside a safe range. The missing protocols were put in place between days 1 and 2 of our inspection. The provider's audits had identified some, but not all the issues we found on inspection.

Staff were unable to describe safe and appropriate action would be taken in the event of an emergency requiring evacuation. The provider told us they would address this with staff. It was not clear how an unsuccessful fire drill had been followed up in January 2023. Safeguarding records, complaints, accidents and incidents did not show how events the provider had marked for further investigation had been followed up. Staff understood safeguarding responsibilities and both people and their representatives said they were protected from harm.

The nominated individual told us they did not produce visit reports as this oversight came from 'Gold Command' (quality assurance) meetings. The provider told us these meetings were documented in emails, but did not present these records. An action plan for previous inspection findings was shared with us. Daily walkarounds were not fully effective and the allocation of 'chart champions' had not improved daily recording. Some items of lifting equipment had not been thoroughly examined as required by the Health and Safety Executive.

Electronic and paper based care planning systems were in the home, but staff were not enabled to access the electronic records, which were the most up-to-date. This was partly addressed during our inspection as the provider printed the electronic records. IT equipment needed to make the electronic care planning system operational was due to be installed shortly after our inspection. Electronic care plans were sufficiently detailed records.

The recording of people's dietary needs was not consistent. People had a positive mealtime experience as staff worked hard to offer people a range of options, which was particularly important where people initially refused what they were offered. Relatives told us they were kept up-to-date around key developments in their family member's health.

Some caring interactions had improved at this inspection. We saw examples of kind interactions, but other examples were seen where staff were not fully skilled. Dementia training which the provider had arranged

with the local authority had to be delayed in February 2023 due to unforeseen circumstances and was rearranged for May 2023. People said the staff were caring and relatives said they had observed improvements. People were more meaningfully engaged with a programme of activities. Activities were also sourced externally and people enjoyed this provision.

Feedback from relatives was generally positive. However, they provided mixed feedback about the responsiveness of the provider's communication, whilst also saying they felt well informed about incidents in the home. The provider acted openly with relatives around shortfalls found at our previous inspection. A culture review completed by a consultant in December 2022 highlighted concerning issues around the provider's management of the home. A new management team had been introduced, although further changes were expected in the months after our inspection. The provider said they would ensure there was a suitable handover to the new management team.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. However, we have asked the provider to investigate the control people have over morning and night routines. We have made a recommendation about the use of best interests decisions, as needed, for this aspect of people's care.

Work had been carried out to improve the living environment and this was ongoing, as some work still needed to be done. Ideas for improvements to the premises were shared by the provider, which included plans to make the home more dementia friendly.

Infection control measures were not robust at this inspection. The premises were found to be cleaner, but some equipment in the home needed a deep clean.

There was an improved skills mix of staff on day and night shifts. Shifts were fully staffed in line with people's assessed needs. Staff files demonstrated the provider carried out safe recruitment checks. Staff were receiving an improved level of formal support through induction, high training completion levels and examples of supervision for some, but not all staff.

We identified two incidents at this inspection which should have been reported to the Care Quality Commission. We have dealt with this outside the inspection process.

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

Rating at last inspection and update
The last rating for this service was inadequate (published 3 February 2023).

The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection we found improvements had been made and the provider was no longer in breach of some regulations. However, we found the provider remained in breach of regulation concerning people's safety and systems to ensure sufficient oversight of the service.

Why we inspected
The inspection was prompted due to concerns identified at our last inspection in December 2022 around safeguarding, management of risk, premises and equipment, staffing arrangements, staff recruitment and

leadership in the home. A decision was made for us to inspect and examine those risks. We carried out an inspection which looked at all five of our key questions.

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 the service can respond to COVID-19 and other infection outbreaks effectively.

The overall rating for the service has changed from inadequate to requires improvement, based on the findings of this inspection. We have found evidence the provider still needs to make improvements. Please see all sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement and Recommendations
We have identified breaches in relation to safe care and treatment and governance of the home.

We have made recommendations about ensuring best interests decisions are in place where needed and assessing how best to support people living with a mental health diagnosis.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Requires improvement'. However, we are placing the service in 'special measures'. We do this when services have been rated as 'Inadequate' in any Key Question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Norman Hudson 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 Health and Social Care Act 2008.

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

Inspection team
The inspection was carried out by three inspectors, a medicines 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
Norman Hudson Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Norman Hudson Care Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered CQC to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A regional manager, who had been working at this home since December 2022, was in day-to-day control of running the service.

This inspection was unannounced.
We visited the location on 22 March 2023 and 23 March 2023.

What we did before the inspection
We reviewed information we received about the service since the last inspection and liaised closely with local authority partners and professionals who worked with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 4 people who lived at the home, 9 relatives, the home manager, the chief operating officer, project manager, activities coordinator, administrator, 2 nurses, 7 care assistants as well as ancillary staff. We observed care in communal areas, including mealtimes on both days.

We reviewed a range of care records, including 5 care plans, medicine records, staff rotas and other documentation to support how the service is run.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

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

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

• Risks within the environment and to individuals were not identified thoroughly or managed safely.
• Care records did not demonstrate people were supported with food, fluids, repositioning, behaviour and continence care. For example, 1 person was recorded as having 1 "small bowel movement" in the eight days prior to our inspection. There was no reference to usual bowel habits in their care records and it wasn't clear who was picking this up as an indicator of ill health. The provider could not show how people were protected from the risk of dehydration and malnutrition.
• Accidents and incidents were recorded, although there was a lack of consistency in how this was done. Follow up action, such as investigation into how these occurred was not always evident.
• Evidence of fire drills was not clear. It was not clear how a fire drill which was abandoned in January 2023 had been followed up. We were given other fire drill records which showed lists of staff signatures without any evaluation of what happened. Two members of staff told us all staff were expected to go straight to a roll call in the car park in the event of a fire, which meant people would be at risk. The provider told us this was incorrect and said they would clarify their expectations with staff immediately following our inspection. Following our inspection, the provider said they had conducted further fire drills.
• The home carried out weekly safety checks on slings and hoists which are used as lifting equipment. Separately, the Health and Safety Executive expects these items to have a Lifting Operations and Lifting Equipment Regulations (LOLER) thorough examination every six months. We identified 7 pieces of lifting equipment being used which had been missed from the most recent LOLER checks at the end of February 2023, which meant people were at risk due to potentially unsafe equipment.
• The provider told us clinical risk meetings had not been held, but said other systems were in place to monitor these risks. Following our inspection, the provider shared minutes for a clinical risk meeting held since our inspection.

This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as risks to people had not been identified or reduced.

• One relative told us, "(Person) did have a fall trying to get out of bed. They (staff) called me straight away and told us what new procedures they were putting in place. They made sure (person's) bed was as low as it could go, plus sensor and crash mats were put on the floor. We felt satisfied with what they did."
• The number of accidents and incidents was seen to have reduced in the months since our December 2022 inspection.
• At our last inspection, bed bumpers were not safe and air flow mattresses were not set correctly. At this inspection, these issues were resolved.

Using medicines safely

At our last inspection the provider did not have robust systems in place for the safe management of medicines. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12. However, concerns were identified in the records relating to medication management.

• Robust medicines records were not in place.
• Quantities of remaining medicines balances for people did not always match the records of doses administered, so we could not be assured medicines were administered as prescribed. The provider had a medication stock count in place to check that medicines were administered as prescribed. However, when discrepancies were noted, these were not always escalated for investigation.
• Guidance and records were not always in place to support the safe administration of topical medicines. We found guidance was not clear for how often creams should be applied and some records were missing. People had patch application records for patches required for pain relief, but these were not fully completed to demonstrate rotation in line with manufacturers guidance to prevent side effects, such as irritation of the skin.
• Some people were prescribed medicines to be taken on a 'when required' basis or with a variable dose. Guidance for how these medicines should be administered was missing for some people. The reason for taking a 'when required' medicine or the outcome was not always recorded to review effectiveness. This meant there was a risk people did not receive their medicines consistently.
• The provider's audits had picked up some, but not all the issues we found on inspection.
• We found no evidence that people had been harmed. However, systems were either not in place or robust enough to demonstrate medicines were effectively managed.

This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as systems were not in place for the safe management of medicines.

Staffing and recruitment

At our last inspection the provider had failed to ensure sufficient numbers of staff were available to meet people's needs. This was a breach of regulation 18(1) Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18.

• There were sufficient numbers of safely recruited staff.
• There was a suitable mix of staff on day and night shifts. People and relatives generally felt there were

enough staff.
• We looked at staff rotas covering the four weeks immediately before our inspection. There were sufficient staff numbers in place, which were determined by an up-to-date dependency tool.
• Agency workers each had a profile with their details and a picture to ensure they were identifiable. However, records to demonstrate these workers received an induction were still not in place. The provider said they would deal with this.
• We looked at three staff files and saw suitable recruitment checks had been carried out. Where overseas workers had commenced their employment, they had the correct checks in place to demonstrate their right to work in the UK.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

At our last inspection, systems were not operated effectively to identify, respond to and report safeguarding concerns. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13.

• People and relatives felt the home provided safe care.
• Safeguarding concerns were not always thoroughly investigated or followed up to ensure appropriate action was taken to prevent a reoccurrence. Where CQC was notified of reportable incidents, the provider said investigations would be carried out, but there was no evidence of these. We have covered this in the well-led section of this report.
• Staff understood how to report concerns if they were worried people were exposed to the risk of harm. They told us they completed safeguarding training to help them identify signs of possible abuse.
• People and relatives told us they felt safe from the risk of abuse. Relatives told us, "Overall I think it is safe" and "I feel safe with the care (person) receives."
•The provider was able to evidence some learning from our previous inspection findings. They introduced initiatives such as swapping the main meal of the day to late afternoon, which they said helped people settle in the evening and sleep well. A system to help ensure airflow mattresses were set correctly had also been introduced.

Preventing and controlling infection
At our last inspection, infection control was poorly managed as not enough action had been taken to prevent the risk of infection spreading. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, there had been improvements, meaning the provider was no longer in breach of regulation 12 relating to infection prevention and control. However, some areas of concern were still identified.

• Infection control procedures were in place in relation to cleaning the home.
• We saw a dirty mattress was brought from another home and put into someone's room without being cleaned. This posed an infection control risk. The provider said this was a misunderstanding as they had expected the mattress was a new one. They took action to ensure the mattress was cleaned once we brought this to their attention.
• Some areas were in need of more thorough cleaning, such as chairs in two people's rooms, some wheelchairs and the floor in the laundry area. There was appropriate use of PPE and hand washing facilities,

which were well stocked. Following our inspection, the provider told us the management team were now responsible for signing off these tasks as completed.

Visiting in care homes
Suitable visiting arrangements were in place. At this inspection, relatives told us the responsiveness of staff in answering the front door had improved.

In January 2023, the provider contacted the Care Quality Commission to advise there had been an outbreak of an infectious disease in the home. One relative told us, "I was made aware of the COVID outbreak, I could still go in, but had to wear a mask. They informed me by email and verbally, plus there was a sign on the door." Another relative said, "After the outbreak stopped, they (staff) were still wearing masks (as a precaution)."

Requires Improvement

Is the service effective?

Our findings

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

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

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

At our last inspection the provider had failed to ensure the premises were adequately managed to maintain people's safety and comfort. This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 15.

• We saw some improvements had been made to the presentation of the home.
• People had undamaged furniture in their bedrooms and radiators along corridors had pleasant looking guards fitted around them. However, radiators in shower areas had not been covered. The provider told us they had to address the most urgent risks before attending to this work, but noted it was part of the home refurbishment plan. Following our inspection, the provider told us these works had been completed.
• Toilet lids remained ill-fitting in several areas of the home. This has been an issue raised in our 2 previous inspection reports and did not ensure people were comfortable and safe.
• One relative told us, "Since the last inspection they have done some painting and a lot more cleaning. I have definitely seen an improvement."
• The provider shared their refurbishment plan with us and told us they wanted to introduce a quiet space, a cinema room, a bar and a dementia friendly high street space. Refurbishment was continuing during our inspection and the provider said they wanted to use colour schemes to help people living with dementia.

Staff support: induction, training, skills and experience

At our last inspection the provider had failed to ensure staff received effective training, support, supervision and appraisal. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18.

• Staff received an improved level of formal support.
• Some examples of supervision provided since our last inspection were seen. Supervisions were being

monitored on a tracker. This remained an area for the provider to continue making improvements in ensuring all staff received their planned supervisions.
• The training matrix we were given identified a list of staff and e-learning modules. Since our last inspection, training completion rates improved and overall, this was at 94 per cent.
• During our inspection, we spoke with new starters who told us they received an induction which included completing online training and four days of shadowing experienced workers.
• Over the 2 days we inspected, there were 3 new care assistants present who were completing their shadow shifts, where they observed the practice of more experienced workers in this home. These workers confirmed they completed online training as part of their induction. However, a worker told us they needed more information about the expectations on them and the routine of being a care assistant. There was a lack of induction evidence for agency staff which the project manager said they would address.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support; Supporting people to eat and drink enough to maintain a balanced diet
• There was a continued lack of oversight of people's daily care to ensure they maintained good health. Care records were inconsistently completed and not checked to identify potential concerns, around care such as skin integrity, constipation, dehydration or basic hygiene.
• The recording of dietary needs was not robust. One person was recorded in the kitchen as level 5 ('mince and moist'), but on 'residents dietary and monitoring' they were recorded as level 6. Two people were recorded in the kitchen as tablet-controlled diabetics, but on the 'residents dietary and monitoring' sheet, this wasn't recorded.
• We observed the mealtime experience on both days of our inspection. We observed staff using 'show plates' to help people living with dementia make a choice about the meal they preferred. Staff worked hard to engage people who appeared disinterested in their food, offering them a variety of alternatives. Monthly catering and dining audits were being carried out and action plans were in place.
• Relatives felt they were kept up-to-date about their family member's health. Feedback included, "They always let me know now (about referrals to healthcare services)" and "They (staff) always inform us. Like (person) needed to see a dietician, so they told us."
• Care plans had been rewritten since our last inspection and showed people's needs had been assessed in order to create these records.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

• The recording of mental capacity and relevant consents was in place for most decisions. Please see our

'caring' key question for more information about recording capacity for night time routines.
• Records of decision specific mental capacity assessments were contained in people's care plans. Where people were assessed as needing a DoLS authorisation, these had been applied for. The provider had a tracker for all DoLS applications and authorisations which helped ensure these were all current and up-to-date.
• Examples of best interests decisions were seen in care records.

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. This domain has not been inspected since 2018.

At our last inspection we rated this key question inadequate. At this inspection the rating has changed 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

At our last inspection the provider had failed to ensure people received person-centred care which met their needs and 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.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 9.

• Improvements were seen in caring interactions, although this was not consistent.
• There was some evidence of care being task focused rather than personalised. Day staff referred to helping night staff and vice versa by supporting people to bed if on days, and getting people up if on nights. Staff told us they did this to help with people's pressure relief and to help them settle. The provider told us they were not aware of this practice and would follow this up to ensure night routines were person-centred.

We recommend the provider refers to current guidance in ensuring decisions made on behalf of people who lack mental capacity are recorded as being in their best interests.

• Interactions between people and staff had improved since our last inspection. Staff engaged with people in a more meaningful way, although this was not consistently the case. Some people remained in their chairs for long periods of time and staff did not always engage with them effectively. Dementia training which the provider had arranged with the local authority had to be delayed in February 2023, but had not since been rearranged.
• Two people we spoke with said the staff were kind and caring. Relatives feedback included, "When I go there, some staff are more clued up than others. Some are quite enthusiastic, and some others look like they don't want to be there", "I would say the majority of staff are 'tuned in' and know what (person) likes. (Person) is certainly clean and has recently been looking better coordinated with clothing and jewellery and their hair is looking nice too. I do think (person) is heard and understood" and "They (staff) do listen and react in a way that reassures (person)."
• People who were unable to mobilise were supported safely using equipment such as hoists. Reassurance was given and staff were patient and careful.

Respecting and promoting people's privacy, dignity and independence

• Staff practice around privacy and dignity remained inconsistent.
• Most people were well presented and dressed appropriately with clean clothes and tidy hair. On occasion, some people's clothing was stained. A relative told us they recently visited and found their loved one with mucus on their top, which they felt should have been identified sooner. Another relative said they raised a query about their loved one's facial hair with staff who subsequently addressed this.
• Some terminology used by staff was not appropriate. For example, staff referred to people as singles, doubles, hoists or by a bedroom number to represent them and their care needs. One member of staff was overheard discussing which people they planned to support and in which order, whilst attending to a person's personal care needs. Following our inspection, the provider told us they were carrying out supervisions with staff to address this.
• There was some improvement in the way people's rooms were personalised with their belongings and toiletries. Individual toothbrushes, toothpaste and hairbrushes were in each room and stored appropriately.
• Relatives consistently told us they felt staff respected their family member's privacy and dignity. A relative said, "My (family member) is ready and well-presented when I take them out. Their skin tone is good and spirit is good."

Supporting people to express their views and be involved in making decisions about their care
• More evidence of the views of people and their representatives was seen at this inspection.
• One relative told us, "Yes, we were (asked about care planning). We were asked if we wanted to put anything in and then review it. It was in the past 2 weeks." Another relative said, "I wasn't involved in (person's) care plan, but I know about it. The staff and I have a good chat when I arrive, so I'm always kept updated." Some other relatives said they were not informed about the refreshed care plans.
• One relative told us, "They (provider) also asked my (relative) what colour (person) wanted their room painted in and I think this is just so good. They are really making strides here."
• A 'you said, we did' board was on display in the home and showed action was being taken in response to feedback passed on by relatives. Following our inspection, the provider sent a satisfaction survey to people's representatives to gather their feedback.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question inadequate. At this inspection the rating has changed 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; End of life care and support

At our last inspection the provider had failed to ensure people received person-centred care which met their needs and 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.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 9.

• Care plans had been rewritten since our last inspection.
• Two care planning systems were in use at the time we visited. An agency nurse we spoke with was using the paper care plans which they said were out of date. They were not aware that electronic care plans had been printed from the electronic care planning system. The home manager dealt with this during our inspection.
• Electronic care plans were detailed, had been reviewed and were mostly up to date. Only managers had access to these care plans at the time of the inspection as the technology staff needed, was not in place. The provider expected this to be resolved shortly after our visit.
• We looked at three end of life care plans. Where relatives engaged with this process, their comments had been added to the record.
• Two people we looked at had a mental health diagnosis and spent the majority of their day in their bedroom. Their care records did not show any current involvement from mental health professionals. Care records were limited in information to show how staff were expected to support these people with their respective conditions.

We recommend the provider refers to current guidance or seeks advice from a reputable source to demonstrate people with a mental health diagnosis are supported to live fulfilling lives.

• People were occupied at this inspection.
• Activities were taking place and people were much more engaged. The activities staff had begun to get to know people individually and said it had taken time for some people to become involved, and this was still in progress.
• People enjoyed arts crafts & painting, looking at newspapers/magazines, having their nails painted and listening to music. People reminisced about music from different eras and spoke about their favourite

singers. A therapy dog came to visit, and the activities staff said this was now arranged for regular weekly sessions. Music for health sessions were taking place before our inspection.
• Two relatives told us their loved one preferred not to engage in activities, but another relative we asked about activities said, "I think on that score, we are pleased that (person) not only enjoys the activities, but is quite active in them."

Improving care quality in response to complaints or concerns
• Records relating to the management of complaints were not well maintained.
• Complaints were not sufficiently recorded or responded to. We were aware of a complaint which we referred to the nominated individual in January 2023, but this was not recorded and there was no evidence of a provider response. Two complaint responses were recorded, but 1 was a response to a CQC enquiry and the other had no information given by the complainant.
• Relatives we spoke with told us, "I did (complain) when (person) went into hospital, as (person) was very dehydrated. When I spoke to the home, they listened and acted on what I said" and "They respond very well on any issue raised."

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

• The provider was aware of their responsibilities to meet people's communication needs.
• Improvements were being made to make the living environment more dementia friendly, which helps people living with dementia understand their surroundings.
• We looked at communication care plans for two people and found these sufficiently considered a range of needs. For example, this included how a person's communication needs changed connected to their health condition.

Inadequate

Is the service well-led?

Our findings

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

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

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

At our last inspection the provider was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as previous breaches of regulation were not met and further breaches were found.

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

• Since our inspection in December 2022, a new management team had been in day-to-day control of the home. This included the chief operating officer, home manager and project manager. Further changes were expected to the management structure, with a new home manager due to start soon after our inspection. Whilst some improvements were seen and the provider was able to evidence they were meeting some of the breaches of regulation identified at our last inspection, there were still shortfalls in the way the service operated.
• At this inspection, risks to people, the safe management of medicines and a sufficient lack of oversight remained a concern. This is the fourth consecutive inspection where breaches of regulations 12 and 17 have been identified.
• Prior to our inspection, the provider informed partners (including CQC) they were holding regular 'gold command' (quality assurance) meetings. We invited the provider to share these records during the inspection, although these have not been presented. The nominated individual had been visiting the home, but confirmed they had not produced evidence of their visits. They said this wasn't needed due to the amount of attention the home had through 'gold command' meetings and consultants. An action plan was shared in relation to findings from our previous inspections, along with a refurbishment plan and other records.
• There was a lack of scrutiny of accidents, incidents, safeguarding events and complaints to demonstrate how opportunities for lessons learned were identified and shared. Concerns we found around the management of medicines had not been identified through systems of audit. Care records and risk assessments were not contained in accessible ways for staff, and there were multi-systems which staff were not all familiar with and therefore presented a risk of unsafe care. Records of people's daily care were poorly completed and did not demonstrate any robust oversight to ensure people's care was managed and

delivered safely.
• A system for having allocated 'chart champions' for food, fluids, bowels and repositioning was found to be ineffective as there were large gaps in these records. Daily checklists were not fully effective as there were issues we found at this inspection which had not been identified. On 20 March 2023, these checks stated boxed medications tallied, which was not accurate. An entry against food and fluid charts stated, 'handed over to staff, chart champions, chart must be kept up to date, complete' and no response times were recorded against 'staff buzzer checks'. This did not demonstrate checking for gaps in recording.
• On 27 December 2022, a consultant produced a report on the culture at this service. Staff felt undervalued and did not feel comfortable raising concerns as they perceived the management put them under 'scrutiny' for raising issues. They were not thanked for raising concerns, they could not see action was taken and their anonymity was not maintained. Staff were asked if they would recommend the home and no one put their hand up to say 'yes'. At this inspection, an action plan was created to address these issues. Staff said they felt confident in approaching the home manager.
• The provider did not have an effective system to ensure that all lifting equipment used in the home had received a thorough examination.

This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as robust governance systems were not evident and previous breaches of regulation were not met.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; 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 December 2022 'culture review' report stated there had been a witnessed allegation of abuse, resulting in action taken by the provider. We were not informed about this incident which is a legal requirement. Another incident was not reported to the CQC as an allegation of abuse. This should have been reported due to a person not receiving pain relief when expressing pain over a 2 week period following an incident. We have dealt with this outside our inspection process.
• Relatives provided mixed feedback about communication from the provider. One relative said they were not informed when their loved one was admitted to and discharged from hospital. They asked for a response from the home and did not receive a reply. Another relative spoke about the recent COVID-19 outbreak and said, "We were informed by telephone call. They (staff) keep us updated with everything." A further relative commented, "There was an incident a few weeks back where the company that delivers the medication to the home was delayed by 24 hours, but they (staff) rang me up to tell me this."
• The provider engaged with relatives about the last inspection findings and their responses. They held relative and staff meetings to deliver key messages. Relatives were recently invited to the home for a Mothering Sunday meal.
• At this inspection, relatives told us, "Yes, things have got better. (Person) is more settled and alert" and "We have been to at least two meetings this year. This was regarding the last inspection. I definitely feel more comfortable about (person) living there. They are doing their 'darndest' to move it forward."

Working in partnership with others; Continuous learning and improving care
• Since our last inspection, the provider had continued to engage with a management consultancy to support improvement in this service.
• A relative commented on the last inspection and how the provider responded. They told us, "I was updated on all the findings. I know who (home manager) is and she is very helpful. I would mark it 7 out of 10 now (overall quality of care). Before I would have given it a 4."
• The local authority and Integrated Care Board (ICB) continued to visit this home on a weekly basis to seek assurances about the quality of care provided.