B & M Investments Limited

Chesham Bois Manor

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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Chesham Bois Manor is a residential care home providing accommodation and personal care to up to 48 people. The service provides support to older people, including people with dementia. At the time of our inspection there were 35 people using the service.

Chesham Bois Manor accommodates people across three units, with two of the units providing care to people living with dementia. The service has a mix of bedrooms with en-suite facilities and other bedrooms where people access the communal bath/ shower facilities. Each unit has its own communal lounge and dining area. The service is set in well-maintained grounds with a secure outside area for people to access.

People's experience of using this service and what we found
People and relatives were generally happy with their care. People told us they felt safe and described carers as "Kind, caring and obliging."

Relatives told us they were happy with their family members care and that most people had good access to health care professionals. They felt the service had improved with regular better trained staff. They commented "[Managers name] and their team are doing a superb job and you can tell they really do care with everything they do," "Care is good and attentive. There is attention to detail," and "Family member has lived in this home for some time now. I think that the home is looking after them well and I think things have been improving. The staff seem happier and are all pulling together better."

A number of relatives felt communication with them and activities available to their family member needed to improve. A second engagement lead had recently been appointed with the aim to develop activities.

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

The provider had been proactive in recruiting staff to provide consistent care to people. Staffing levels had improved and were sufficient, with agency use decreased. Staff told us the training provided had improved, however key training was overdue and competency assessments were incomplete and others unavailable.

Auditing and monitoring of the service was taking place which showed the provider had identified, shortfalls in the service provided. Improvements had been made to records, however further improvements were required to ensure records were accessible, accurate and suitably maintained.

Most risks to people were identified and mitigated, with staff aware of people's risks and how to support them. Where risks were not mitigated this was immediately addressed. Safe medicine practices were promoted.

Systems were in place to safeguard people with evidence of learning from incidents to prevent reoccurrence and safeguard people.

People's nutritional and hydration needs were identified, monitored and action taken where records did not evidence people had the required food and fluid.

The manager had been proactive in making improvements to the service, which included creating a more positive culture which promoted positive outcomes for people.

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 13 January 2022). 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, however further improvements were required to be fully compliant with the regulations reviewed.

The service had been in Special Measures since December 2021. During this inspection the provider demonstrated improvements have been made and their audits had identified the areas that still needed improving. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected
We carried out an unannounced focused inspection of this service on 9,10 and 17 November 2021. 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, safeguarding, recruitment, staffing, training, good governance and need for consent.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe, Effective and Well-Led which contained those requirements and warning notices.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from inadequate to requires improvement. This is based on the findings at this inspection.

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.

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 Chesham Bois Manor 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 monitor the service and will take further action if needed.

We have identified continued breaches in relation to training, consent and records at this inspection. However, in view of the progress made within the service we have taken a proportionate response to the continued breaches.

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

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Chesham Bois Manor

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 one inspector over two days with an Expert by Experience on site on day two of the inspection. A second Expert by Experience carried out calls to relatives after the inspection.

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
Chesham Bois Manor is a 'care home' without nursing. 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. Chesham Bois Manor is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was not a registered manager in post. A manager was managing the service. However, they were leaving the service In July 2022 with the Head of Governance taking on that role

to give the provider the time to recruit a suitable manager.

Notice of inspection
This inspection was unannounced.

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

During the inspection
We spoke with fourteen people who used the service and two relatives about their experience of the care provided. We spoke with eight staff including the manager, deputy manager, assistant manager, operations manager, senior administrator, senior carer, carer and head of housekeeping.

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

We reviewed a range of records which included, multiple medicine records, five staff recruitment files, supervision and training records. A variety of records relating to the management of the service, including health and safety, audits and cleaning schedules were reviewed, and other records were requested.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at policies, eight electronic care plans, meeting minutes, training data and quality assurance records. We spoke with five relatives and received written feedback from a further three relatives.

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 (Safe Care and Treatment) 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, further improvements were required to risk management, which was addressed.

● Risks to people were identified and mitigated such as risks associated with nutrition, hydration, choking, falls and pressure damage. Turning charts, food and fluid charts were audited daily and immediate action taken, such as skin integrity checks and increasing fluid intake to mitigate risks to people. In records viewed we saw a person who was a choking risk was offered ice lollies. This had been identified as a risk by the service, was addressed and staff informed. However, the risk assessment was not updated to reflect the risk.

● People's care plans included guidance on managing their distress, although further work was required to include more specific details on the behaviours presented and how to deescalate if initial interventions were unsuccessful.
● In our review of care plans we found a person's whose mobility had decreased did not have a moving and handling risk assessment in place. Another person had type 2 diabetes and the risks around this were not identified and mitigated. This was pointed out and addressed. The provider's quality monitoring audit carried out in May 2022 had identified the sample of care plans audited by them needed to improve with more detail required, which was being addressed.
● Staff were aware of risks to people, including risks associated with medical conditions and distressed behaviours. We observed they supported people appropriately at mealtimes, when mobilising and used moving and handling equipment safely.
● Health and safety checks took place which included fire safety, window restrictors, water temperature and crash mats checks. Legionella testing was completed and equipment such as the lift, fire equipment, gas, electricity and hoists were serviced. An up to date fire risk assessment was in place. People had personal emergency evacuation plans (PEEPs) on file and records viewed showed fire drills took place quarterly with actions taken where the response to the fire drill was not deemed satisfactory.

Staffing and recruitment

At our last inspection recruitment procedures were not operated effectively to ensure fit and proper staff were employed. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 19. However, further improvements were necessary to ensure recruitment records contained all of the required information, which was addressed.

● Systems were in place to promote safe recruitment practices however; this was not consistently applied. In the staff files viewed two references were obtained, but references were not always checked against a candidate's employment history to establish the relevance of those. This was discussed with the provider to ensure that a record was maintained to explain the rationale for not seeking a reference from most recent employers.
● Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. In view of the need to recruit staff to meet the needs of the service the provider had made the decision to recruit staff on a DBS adult first check, whilst waiting for the full DBS to be returned.
● A risk assessment was in place to support the decision which was a generic risk assessment and indicated the staff members worked in a shadowing capacity, which we saw was not the case. This was updated at the inspection, when the manager established that two of the three staff with only a DBS adult first check on file had already received their full DBS.
● Four of the five staff recruitment files viewed did not have a recent photo and one of the files had not signed the associated forms for their employment such as their health questionnaire. The checklist at the front of the staff file indicated the files had all the required information. However, the providers monthly monitoring audit completed in May 2022, indicated a senior administrator from head office was working in the service from the 17 June 2022 to audit a sample of new staff files as some concerns had been identified by them around those records. Whilst this was scheduled it had not been completed at the time of the inspection. After the inspection in view of our findings the provider audited all remaining staff files and addressed shortfalls.

At our last inspection sufficient numbers of staff were not provided. This was a breach of regulation 18 (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(1).

● Sufficient staff were provided. The staffing levels per shift were confirmed as eight staff on the daytime shifts and four staff on the night shift. The rotas viewed from the 13 June to 3 July 2022 showed the required staffing levels were maintained with the assistant manager regularly working alongside staff on shifts and a team leader and /or senior on shift to manage the shift and take responsibility for medicine administration.
● Since the last inspection there had been a high turnover of staff, with new staff recruited which had resulted in a reduction of agency use. This promoted continuity of care for people.
● People and their relatives did not feel the current activities available was stimulating or sufficient. Relatives commented "Apart from a few activities, I see very little to interest or stimulate the residents," "There is not a lot of social engagement at the moment," and "There are no activities happening at the moment and this has been a weakness in the home for quite a long time."
● The service had one engagement lead which limited the activities made available to people. The provider was aware people had limited access to activities. However, a second engagement lead staff member had

been recruited to support the development of activities and engagement with people. It was hoped this would lead to improvements.
● Staff told us the required staffing levels were maintained and staffing was sufficient. Staff commented "Staffing levels seem appropriate," and "Staffing has improved and there is less agency use which makes a big difference to the care people receive".
● Some people did not feel there was enough staff, especially at weekends and mealtimes. A person commented "Staff are rushed off their feet." Whilst other people felt staff were on hand when needed.
● Relatives felt staffing had improved with more permanent staff in post. Relatives commented "The staffing is generally improving, and some high-quality care staff are now starting and being trained. They are impressive, caring and compassionate," and "When we visit, we see the same faces which suggests continuity of care," and "I feel the way the staff speak with my relative is excellent. They are calm and reassuring."

Systems and processes to safeguard people from the risk of abuse

At our last inspection people were not safeguarded from the risk of abuse. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) 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.

● Systems were in place to safeguard people. After the last inspection safeguarding incidents came to light which had not been reported and acted on to prevent reoccurrence. As a result of these and our last inspection, face to face safeguarding training had been provided to upskill staff. This was to ensure they were clear of their responsibilities to report safeguarding incidents and poor practice.
● Safeguarding policies and procedures were in place, a safeguarding information table was provided, and notice boards were updated with safeguarding information. The service had improved multi-disciplinary working with outside agencies, and they had provided training to relatives to raise awareness of safeguarding.
● Staff spoken with confirmed they had received safeguarding training with the deputy manager attending a two-day safeguarding training. Staff commented " All staff are able to recognise safeguarding and do report," " Poor practice is not tolerated and always addressed with staff shown how to improve their practice too," and "Concerns reported are always acted on which reassures me that people are safer."
● Systems were in place to observe staff practice to further safeguard people. There had been an increase in safeguarding notifications from the service, which assured us safeguarding was recognised and responded too appropriately.
● People felt safe and their relatives believed they received safe care. They gave us examples where staff had ensured their safety. Relatives commented, "Yes, I don't see any evidence of unsafe care. [Family members name] biggest issue was their balance, so they tend to fall easily. Since moving to Chesham Bois Manor, they have never been left alone whilst doing anything other than sitting in a chair or asleep in bed" and "[Family member's name] is more settled and happier now. I feel their care is safer than before and they are now wearing their own clothes and is looking cleaner and better presented."

Using medicines safely
At the last inspection safe medicine practices were not always promoted. This was a breach of regulation 12 (Safe care and treatment) 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.

● Systems were in place to promote safe medicine practices. The provider had a medicine administration policy in place and staff involved in medicine administration were trained and had their competencies assessed to administer medicines.
● Medicines were suitably stored and at the recommended temperature. A record was maintained of medicines ordered, received, administered and disposed of. Where interim prescriptions were required these were handwritten and included two staff signatures.
● Protocols were in place for "as required" medicines and homely remedies were agreed with the GP.
● The medicine administration records viewed showed medicine was given as prescribed and systems were in place to audit medicines to ensure stock checks were maintained and accurate.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections. On arrival we completed a questionnaire and we were asked to show evidence of a lateral flow test result.
● 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 using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
The service was open to visitors with visits taking place during the inspection.

Learning lessons when things go wrong
At the last inspection systems were not established and effective to promote learning from incidents to prevent reoccurrence and promote safe care and treatment. This was a breach of regulation 12 (Safe care and treatment) 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.

● The provider had systems in place to promote learning when things went wrong. The electronic reporting system enabled the provider to analyse falls, complaints, safeguarding's and identify trends to prevent reoccurrence. These were also reviewed at the monthly provider monitoring visit to ensure actions were taken.
● The daily morning meetings, clinical governance meetings and staff meetings showed discussions and lessons learnt were discussed with staff following any incident which placed a person at risk.
● Alongside this, the manager was proactive in addressing poor practice and staff failures to maintain accurate records to prevent reoccurrence. A lesson's learnt record was completed and cascaded to the whole team.
● A staff member commented "Every poor practice observed becomes lessons learnt or a supervision. We do not just point out to staff their mistakes but show them what to do. However, we do not tolerate poor

practice."

Requires Improvement

Is the service effective?

Our findings

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

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

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

At the last inspection the service was not working to the principles of the Mental Capacity Act 2005. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

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

- Staff were trained in the Mental Capacity Act 2005 and demonstrated some understanding of the principles of the act. Mental capacity assessments were completed with best interest decisions recorded for specific decisions. However, these were not consistently completed for everyone.
- Of the eight care plan files, seven people were deemed to not have capacity to make decisions on aspects of their care. However, five people did not have a MCA for the use of CCTV in corridors, four people did not have an MCA for medicine administration, four people did not have an MCA for Covid -19 testing which we saw had taken place and four people did not have an MCA for restrictions such as the use of a sensory mat, one to one care, locked bedroom door at night and moving units within the service.

This is a continued breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The providers audit showed mental capacity assessments were rated amber which indicated training was not embedded into practice, and they recognised further work was needed to achieve full compliance with regulation 11.
● A record was maintained of Deprivation of Liberty Safeguards (DoLS), which showed the date the referral was made and outcome.

Staff support: induction, training, skills and experience

At the last inspection staff were not suitably inducted, trained and supported in their roles. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18(2)(a).

● Since the last inspection the training department had co-ordinated and facilitated training in the service. The training matrix provided showed gaps in training and a low percentage of training for medicine administration, infection control and behaviours that challenge. The training schedule did not include training in those topics either. The staff files viewed did not include evidence of the training provided and the organisations electronic system was not updated with all of the training undertaken so we were not able to have an overview of the training undertaken by individual staff. Evidence of training for five staff was provided after the inspection and a revised training plan was put in place.
● Staff new to care were enrolled on the Care Certificate training. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme. However, records of competency assessments were not available to indicate staff competencies had been assessed and signed off.
● The personal care competency assessments were last completed in Feb 2022 with one staff member assessed as a B in most areas which meant they did not follow procedures. There was no indication this was addressed, and they were not reassessed again to establish if their practice had improved. A moving and handling practical tracking record completed on the 15th June 2022 showed some staff were not ticked as competent in all areas but there was no follow up to that. Alongside this "The understanding the organisation and the role of the worker form" was incomplete in all new staff files viewed.
● The training department had introduced a mentoring system for new staff. however, this was not fully established as the training for mentors had only just been completed but the mentoring timetable had already commenced.

This is a continued breach of regulation 18 (2)(a), (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● It was not established and agreed who had oversight of the training which included completion of competency assessments such as the personal care competency assessments. The provider audits showed they had identified shortfalls in training. They assured us this was being addressed and completed a lesson's learnt exercise after the inspection which identified there was a lack of collaboration between the training department and the service. Actions were agreed which included the training manager having oversight of

the training and ensuring accountability was given to a staff member when handing over a task such as competency assessments.
● Staff told us they had received an induction and training and that the quality of the training had improved with face to face training provided as well as training specific to their role.
● The manager had held choking drills with staff to develop their skills and confidence to manage a choking incident and staff involved in medicine administration had their competencies assessed to administer medicines. Alongside this regular observation of staff practice was taking place to assess if training was embedded into practice. Where concerns were identified further support and training was provided.
● Staff told us they felt better supported and had regular supervision. We saw regular supervision of staff took place, particularly in response to their practice.
● Some relatives told us that they felt staff were better trained A relative commented "Following a very difficult period when many staff had left to be replaced by agency staff, there has been a marked improvement in the numbers and quality of new staff."

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

At the last inspection people's nutritional and hydration needs were not met. This was a breach of regulation 14 (Meeting nutritional and hydration needs) 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 14.

● People's nutritional and hydration needs were identified, and measures were in place to ensure they were met. Care plans identified the support people required with meals and drinks. During the inspection we observed people were supported with their meals in a timely manner, except for one person whose meal was left in their bedroom with them. The staff member on tray duty and responsible for overseeing people with their meals in their bedrooms had failed to do that. This was immediately addressed with them and the shift planner was updated to ensure this was formally allocated and recorded.
● People's weights were monitored, and action taken in response to weight loss, including informing the GP, offering people fortifying meals and ensure milkshakes (which is a nutritional supplement).
● A sample of fluid charts were viewed, which showed a daily target fluid intake was agreed for individuals. The fluid and food charts were audited daily, and action taken to address shortfalls in recording to ensure that the required fluids were offered and drank by individuals.
● We observed meals over the two days of the inspection. The mealtime experience was calmer and better organised than at the last inspection. People were shown two options of the meals available to enable them to make an informed choice and were offered a choice of two drinks.
● Staff were allocated tables that they were responsible for at mealtimes, however this was not fully embedded into practice which resulted in a lack of oversight of mealtimes with different staff asking people the same questions in relation to their meal. The assistant manager identified this and reminded the team leader of the need to ensure tables are allocated to staff to promote continuity of care at mealtimes.
● People were generally happy with the meals provided. They described them as varied and tasty.
● Relatives told us that nutrition and hydration was a high priority for the service, with one relative telling us that their family members weight had increased which they felt suggested they got the support they required. Relatives commented, "Whenever I am with my [family member] there are ample nutritional and hydrational items available," and "My [family member's name] has told me the food here is close to excellent."

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

● People were assessed prior to admission to the service. Their preferences, religion, cultural and diverse needs were identified and met. Staff were trained in equality and diversity to enable them to support people effectively.

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

● People had access to other healthcare professionals such as a chiropodist, opticians and dentists. A GP visited the service weekly to review people and appropriate referrals were made to the district nurse team, speech and language therapists and mental health team when required for individuals.

● People told us they could see the doctor if they needed too. Most relatives confirmed their family members had excellent access to health professionals and felt the service sought medical advice promptly. A relative commented, "They have a very good clued-up GP who visits weekly. She's thoughtful in prescribing meds and recognising changes." One relative felt the service was slow in accessing dental treatment for their family member or recognising hearing issues, which they believed was now being addressed.

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

● Areas of the service had been refurbished, decorated and at the time of the inspection refurbishment of another unit was underway with further improvements to the service planned. Whilst people and families found this disruptive, they could see the benefit of it too.

● The service was being refurbished to meet the needs of people using the service. Signage, bright colours, sensory and visual displays were on corridors to orientate people with dementia and promote their independence.

● Handrails were in use in corridors and a chair lift and passenger lift was available to enable people to access other floors. At the time of the inspection the people lift was not working with alternative arrangements made to move people between floors. Some relatives told us this was out of use for some time which impacted on their family member. The service was working with the engineers to address that. Keypads were in use in dementia care units to promote people's safety.

● The home was set-in well-maintained grounds with people having access to an enclosed secure outside area. Garden tables, chairs and umbrellas were provided to enable people to access the secure outside area safely in the summer.

Requires Improvement

Is the service well-led?

Our findings

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

At our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

At the last inspection good governance was not established, and records were not suitably maintained. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made to record management at this inspection and the provider was still in breach of regulation 17(2)(c).

● Some people's files were contradictory or incomplete. In one person's file it was recorded they were on a level 4 food and drink consistency to mitigate a choking risk. On the review of the risk assessment it was recorded they were on a soft diet and thickener level 2. A person's falls risk assessment was not fully completed to include reference to the medicine they were on, which meant the overall risk score was not accurate and another person's file indicated bed rails were in use which the manager confirmed was not the case. Some mental capacity assessments were not fully completed to indicate if a DoLS application had been made.
● Training records were not suitably maintained and accessible with information not filed in a timely manner. The electronic reporting system was not consistently updated with the training undertaken. Therefore, we were not able to access records we required during the inspection. Recruitment files did not contain all of the required information and were not routinely organised in line with the dividers in the files.
● Supervision records were not available for supervisions that were recorded as having taken place on the supervision matrix and there was a back log of supervision records awaiting filing. The high touch cleaning records were not routinely completed, to be assured the high touch areas were regularly cleaned.

This is a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had identified people's daily records and monitoring charts such as food, fluid turning charts, personal care records were not always completed accurately or left blank. A member of the training department was working alongside staff to bring about improvements.
● Auditing was taking place which included a series of in-house audits such as infection control, catering, medicines, oral hygiene, weight audits, rotas and alarms. Alongside this the manager and assistant manager

observed and audited staff practice and people's records, as well as carrying out, out of hours visits to the service. Actions were taken to address findings.
● The provider was able to audit aspects of care from the electronic monitoring system in use. This enabled them to pull off reports on accidents, incidents, complaints, safeguarding and review care plan files remotely. Alongside, this they carried out monthly provider audits and a six-monthly comprehensive audit. The audits viewed showed the provider had identified areas that needed to improve such as training, mental capacity assessments, people's files and recruitment files, which are the areas we found the service still needed to improve on. A service improvement plan was in place which outlined areas for improvement and who was responsible for making those improvements.
● The service did not have a registered manager. A new manager was in post since February 2022 but was due to leave in July 2022. The head of governance had agreed to manage the service until such time as a new manager commenced and was inducted. The manager in post at the time of the inspection was clear of their role and responsibilities and had made positive changes to the service.

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

At the last inspection the service was not effectively managed to provide good outcomes for people. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement has been made at this inspection and the provider was no longer in breach of regulation 17(2)(b).

● The manager had worked hard to change and improve the culture within the service. Poor practice was immediately dealt with and staff were supported to improve to promote positive outcomes for people. Communication systems were developed, and clear lines of responsibility and accountability were established to promote safe care.
● The manager had an open-door policy and made themselves accessible to people, relatives and staff.
● Staff described the manager as approachable, accessible, competent, experienced, kind calm, who displayed positive energy around the team and was a positive role model. Staff commented "The vibe has changed, it is relaxed and communication is better," "Management are easy to approach and a breath of fresh air, right now we are in the good place," "The manager provides clarity, is able to project manage and is clear about what she wants to achieve," and" The [manager's name] has taught me a lot, matters are addressed, communication has improved, she had created a better atmosphere which is calm and staff are enjoying work and willing to do extra shifts."
● People told us they felt able to raise concerns and those were addressed. Relatives felt the service was better managed and safer. Relatives commented "I sense that the home is well managed and that a sound structure and ethos is being introduced. I don't have a feel for the manager's involvement in the daily business, but they generally seem well informed. The manager is very approachable but also difficult to approach as they have incessant meetings in their office. They have built a good team and I have always found a means of seeing them if I feel I really need to do so", "[Managers name] has been brilliant from day one, I firmly believe they have turned things around and is always ready to talk to me if required," "I think things have been improving. The staff seem happier and are all pulling together better," and "I think the manager has been a very good manager with true vision."

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 provider had a duty of candour policy in place, which was developed in line with the regulation.
● There had been no recent duty of candour incidents. However, the manager was aware of their responsibilities under the duty of candour regulation and was open and transparent in their engagement with people, staff, relatives and professionals.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Systems were in place to get feedback from people, relatives and staff. A safety audit had been completed with people which showed they felt safe. Zoom meetings had been set up with families to keep them informed. Staff feedback was sought, and action taken with a "you said, we did" notice on display.
● Systems had improved to promote communication and teamwork. Key worker roles had been introduced and were being developed to promote people and family's involvement in their care. Some relatives had regular engagement with key workers and involved in care planning, whilst other relatives had not established those relationships with keyworkers and did not feel involved or able to contribute to their family member's plan of care.
● Regular team meetings and clinical review meetings took place where actions were agreed and implemented. Daily 10 at 10 meetings were structured with a shift planner and a revised handover process introduced.
● Staff felt better informed and confirmed teamwork, handover and communication had improved. A staff member commented "People get better care and families are engaged with. They feel happy with the changes and the communication with them."
● Most relatives felt the zoom meetings were positive and they had been given key information about the service. However, many relatives felt communication was still poor with a number of relatives raising concerns about the difficulty they had in contacting the service, with the phone often engaged and no option to leave a message, or the phone not answered and emails to senior staff were not always responded too. This was fed back to the provider to address.
● Relatives recognised the improvement in teamwork. A relative commented "There is now a real feeling of team working which as a relative, I feel is great. There is also a sense that the management structure has improved and also that the quality and standard of training has greatly improved."

Continuous learning and improving care Working in partnership with others

At the last inspection continuous learning and working with others was not established to improve care for people. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement has been made and at this inspection and the provider was no longer in breach of regulation 17(2)(a).

● The manager was committed to developing and coaching staff to improve care to people. Alongside this they had accessed training from the local authority on topics such as nutrition and using the malnutrition screening tool.
● The service worked closely with health professionals and was receptive to their input and advice to benefit people.

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 11 HSCA RA Regulations 2014 Need for consent The service was not working to the principles of the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Records were not suitably maintained, accurate and up to date.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not suitably inducted and trained to meet people's needs.