Barchester Healthcare Homes Limited

Lancaster Grange

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
The home provides accommodation, nursing and personal care for up to 60 older adults and people living with dementia. There were 55 people living in the home on the day of our inspection. The home accommodates 55 people across four separate wings over two floors, each of which has separate adapted facilities. One of the wings specialises in providing care to people living with dementia.

People's experience of using this service and what we found
People, relatives and staff consistently told us that staffing levels were not sufficient to meet the needs of people using the service. Records showed that staffing levels did not always reflect the ratio stipulated by the provider. Observations during the inspection confirmed that people are often left unattended while staff are dealing with other issues.

Risks were not being managed effectively. People at high risk of skin breakdown were not being repositioned at the agreed intervals. Fluid intake was not always being recorded for people and risks associated with choking and falls were not being managed effectively which placed people at risk of avoidable harm.

Medicines were not managed effectively. People were at risk of not having medicines administered as prescribed.

Systems and processes were in place to ensure that the home was clean and to reduce the risk of spread of infection. Systems and processes were in place to protect people from abuse, staff were knowledgeable about how to respond to abuse.

Advice provided by health professionals was not always acted upon.

Records showed that people are assessed prior to admission and have a full care plan developed following this. Staff receive the training they need to meet people's needs. People received a nutritious healthy diet and have access to drinks and snacks.

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.

Staff were observed to be kind and caring toward people. People and relatives spoke very highly of the staff and have told us that they are happy with the way that staff interact with them.

People and relatives told us that their views and opinions were not always listened and responded to.

Staff were knowledgeable about how to maintain people's privacy and dignity. People and relatives confirmed that staff do their best to promote people's independence and maintain their dignity. Staff understood the principals of confidentiality.

No one living at the home was at the end of their life. Staff were knowledgeable about how to support people at the end of life to ensure that they had a dignified death. Future planning had been done with people to ensure that their wishes were reflected clearly.

The home was without a registered manager and a deputy manager. The deputy manager had been appointed and was due to start their role. An experienced operations manager had been appointed internally on a temporary basis and was in the process of registering themselves to act as the registered manager. At the point of writing this report, we have not received an application.

Governance systems and audits were in place and used regularly but did not always identify risk. Risk that was identified during the inspection had not been identified in previous audits. Manager's walk rounds had identified some issues and were being addressed.

Relatives have told us that they did not feel that the organisation listens to concerns and often does not communicate effectively with them.

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

Rating at last inspection
The last rating for this service was Good (published 18 October 2017)

Why we inspected
The inspection was prompted in part due to concerns received about staffing. A decision was made for us to inspect and examine those risks. We have found evidence that the provider needs to make improvements. Please see the Safe, Effective, Caring, Responsive and Well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.
The overall rating for the service has changed from Good to Inadequate. This is based on the findings at this inspection.

Enforcement
We have identified breaches in relation to Regulation 18 Staffing, Regulation 12 Safe Care and Treatment, Regulation 14 Meeting Nutritional and Hydration Needs and Regulation 17 Good Governance at this inspection.

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

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This

means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate

Lancaster Grange

Detailed findings

Background to this inspection

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

Inspection team
This inspection was carried out by an inspector, an assistant inspector, a nursing specialist advisor 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
Lancaster Grange is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission.

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

During the inspection

We spoke with 12 people who used the service and 17 relatives about their experience of the care provided. We spoke with 14 members of staff including the manager, senior care workers, care workers, domestic staff, catering staff and nursing staff. We reviewed a range of records. This included 10 people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

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

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate.

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

Staffing

● Staffing levels were insufficient to meet people's needs and keep them safe. The provider used a dependency calculator to establish the required number of staff each day. The manager told us staffing levels should be 12 staff (including two nurses) on the early shift, 10 staff (including two nurses) on the late shift and six staff (including one nurse) on the night shift. From the 22 May 2019 – 03 June 2019 there were nine days where the early shift had insufficient numbers of staff, four days where the late shift had insufficient numbers of staff and three days where there were insufficient numbers of staff on the night shift. We reviewed staffing records for 4 March 2019 to 10 March 2019 and found seven occasions where there had been insufficient staffing.

● People consistently told us about the negative impact staffing shortages were having on their health and wellbeing. One person said, "Understaffing is the problem. There used to be three staff on each section and now it's down to one. One person on in a morning is not enough. It's impossible to get people up, washed and dressed with just one when it needs two people. Usually you have to wait 15 to 20 minutes in a morning if you buzz to go to the toilet and sometimes it's up to 45 minutes and there's usually no one available to cook breakfast in the dining room because they're busy helping people."

● Relatives described their anxiety in relation to insufficient staffing. A relative told us, "At weekends sometimes it can be the afternoon before [relative] gets personal care. There's no stability or continuity of carers. There's a lack of communication between carers and people (staff) aren't always sure what needs to be done. [My relative] has a swallowing problem and if someone's not familiar with them they won't necessarily lift [my relative] to support them to eat. [My relative] has now got pressure sores which could have been picked up more quickly."

● Observations during the inspection corroborated the serious concerns shared by people and relatives. On the second day of inspection we observed four people who were alone in the kitchen and dining area on the dementia wing. One person was holding on to a ceramic hotplate which was switched on. Another person was distressed and wanted to use the toilet. Staff told us they were supposed to supervise the communal areas, but it was impossible to achieve while providing care to other people in their rooms. We also observed a person nearly pull a bookcase on to them, only the intervention of the inspector prevented a serious accident.

● Staff consistently told us that they were very concerned about staffing levels. One staff member told us, "It's like running on a hamster wheel and getting nowhere. There are 30 resident's downstairs with three care staff, if two staff are administering medicines it only leaves one staff to attend to their needs."

● Records relating to people's care were often not updated. For example, on the second day of inspection one person's records indicated that they had not been supported to go to the toilet for the duration of the

previous day. Another person's records indicated that they had not received any care since 20:35 the previous day.

People's needs were not being met due to insufficient levels of staffing. This placed people at risk of harm. This was a breach of regulation 18(1)(Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Using medicines safely

- Staffing shortfalls resulted in risk management plans and care plans not being followed, placing people at risk of avoidable harm. For example, one person had several pressure ulcers and was recorded as a very high risk of skin breakdown. The person's care plan stated they required two hourly repositioning by two staff during the day and at four hourly intervals at night. Records showed during a two-day period in June there were six separate occasions where repositioning did not occur as described their care plan. On one occasion they were left for up to seven hours in the same position.
- We noted that the same persons care plan stated that they required a slide sheet to be used for repositioning to reduce the risk of damage to their skin. We were told by the person that staff did not always use the slide sheet. Despite the person requiring two staff to carry out repositioning we noted that Records of repositions often contained only one staff signature which could be interpreted as the person being repositioned by one staff member we raised this with the provider who assured us that they would review records to ensure that two signatures would be included in the future.
- Several people were recorded as being at risk from skin breakdown. Care plans stated repositioning at two- and four-hour intervals was required to alleviate pressure. Records showed several occasions where they were not repositioned and on one occasion a person was left in one position for eight hours. Records also showed that creams prescribed to prevent pressure ulcers developing for several people were often not applied.
- People who were at risk of choking were being placed at an increased risk due to assessments and plans not being followed. For example, one person's food chart asked, 'is there an identified risk of choking?' Staff had circled 'No' which contradicted the swallowing assessment carried out by a speech and language therapist. We observed a bowl of stodgy cereal was within reach. We did not see staff in the vicinity. Food charts stated that the person had previously been given walnut whip, fish and chips and crisps, all high-risk foods which had been advised against. We also noted that their care plan stated staff should observe the person when eating.
- On the second day of inspection we noted several people sitting in the dining area eating food unsupervised. Records showed they had been identified as being at risk of choking.
- People were at risk of not having their medicines administered safely. For example, two people were having their medicines administered covertly which means that medicines are hidden in food or drink. There is a risk people may absorb the medication quicker than intended and suffer side effects. It may also affect the active ingredient of the medicine. The care plans for medicines stated that the GP and a pharmacist were consulted but contained no details as to what advice the pharmacist had given.
- During a walk round on the first day of inspection we identified that thickeners were not stored correctly. Thickener was found in both kitchenettes on the ground floor and left unsupervised on the worktop. NHS England issued a safety alert in February 2015 of the need for proper storage and management of thickening powders; this was in response to an incident where a person died following the accidental ingestion of thickening powder.
- Several people were prescribed medicines on an 'as needed' basis. There were not always clear and comprehensive protocols for these.
- Some people were prescribed pain relief. Care plans indicated whether the person could say if they were experiencing pain. People who were unable to communicate did not have descriptions of non-verbal

behaviours when they were experiencing pain or discomfort and was not formally assessed, this placed people at risk of experiencing unnecessary pain.
● Some medicines were recorded as being out of stock and some people had not received their medicines for several days.
● Relatives expressed concerns about medicines, one relative told us, "[Relative] isn't able to take them without help and staff know [relative] doesn't want to take them. I think they're putting tablets on the tray with breakfast rather than ensure they have been taken and [relative] was putting them in their bag. When I raised it with the manager they took the bag off the tray, but I'm still finding pills on the floor in the room."
● People were also at risk from health conditions that were not being managed sufficiently. For example, two people had diabetes and required support to manage their blood glucose levels. Records showed that there were several occasions where levels were dangerously high, but there was no evidence that action had been taken or advice had been sought. Advice provided by the diabetic nurse stated that one person should have blood glucose tests twice weekly, but we could find no evidence that this advice was being followed.

The providers failure to ensure that risks were mitigated to ensure peoples safety placed people at risk of avoidable harm. This was a breach of regulation 12 (1) (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● The building appeared clean and hygienic throughout. The provider had an infection control policy which staff could refer to. Records showed that staff had received infection control training.
● We spoke with housekeeping staff and were told that there were clear and structured cleaning schedules to ensure that people's rooms and communal areas were kept clean and hygienic.
● There were designated areas to ensure that contaminated bedding and clothing could be cleaned and kept separate.

Systems and processes to safeguard people from the risk of abuse
● People were cared for by staff who knew how to protect them from abuse. The provider had a safeguarding policy which staff were aware of.
● The registered provider ensured that staff received safeguarding training so that they knew how to identify abuse.
● Staff were aware of the whistleblowing policy and what it was used for.

Learning lessons when things go wrong
● People who were at risk of falls were being placed at increased risk due to insufficient analysis. Records showed that one person had a fall during April 2019 the incident form showed that there was no subsequent analysis. The person fell again the following day and sustained skin injuries. Their care plan was updated in August 2018 stating, 'no falls in last six months so no longer checked on hourly in the night'. The person suffered a fall in September 2018 and the care plan was reviewed six days later but did not reference the fall. Four further reviews between October 2018 and February 2019 did not reference the fall and no changes were made.
● The provider had a system to establish the cause of pressure ulcers acquired in the home called a 'root cause analysis'. We noted that a root cause analysis had been carried out for one person. We identified that the process had failed to establish if repositioning to alleviate pressure had been achieved according to care plans and whether the application of preventative barrier creams had been routinely carried out. This limited the providers ability to establish whether pressure care was effective.
● We inspected another of the providers homes earlier in the year and found similar concerns relating to staffing and safe care and treatment. Based on findings from this inspection it does not appear that lessons

have been learnt.

Recruitment

● The provider had a process for ensuring that staff were recruited safely. We checked recruitment files of staff working at the home and saw that pre-employment checks were undertaken prior to staff commencing employment. Staff had Disclosure and Baring Service (DBS) checks in place. The DBS is a national agency that keeps records of criminal convictions.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement.

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

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

- People who were at risk of dehydration were not being supported to drink enough fluid. One person's care plan stated their target intake was 1740mls. We noted their fluid chart for the previous day stated they had only received 800mls. Another person's fluid chart confirmed they had received 230mls before 12:30pm and was not offered another drink until 23:00 when they drank 200mls. One relative told us that when they arrived to visit, their family member's mouth was often very dry and due to the thirst, they were experiencing they drank quickly placing them at risk of choking.
- We observed lunch on the dementia wing. The experience for some people was not enjoyable. A nurse assisted one person to eat in their room and a visitor assisted another person. Two care staff had the responsibility to monitor and assist 12 people. Some people were in their bedrooms and some were in the dining area. We noted that one person who was in their room was shouting for help and seemed unhappy about the food they had been given, but staff were unable to assist. One person left the dining area suddenly and staff were unable to find out why, so the person did not finish their meal.
- Dining tables were not set resulting in people having no napkins, tablemats or cups. People either had to wait for things or were not offered them. We noticed that no one was provided with a drink with their meal from the start. People had to request one or wait for staff to realise.
- People told us that they enjoyed the food served in the home, one person said, "The food is quite good and there's usually something I like."

The provider's failure to ensure people's nutritional and hydration needs were properly met and monitored was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Staff expressed frustration about the consistency of staff working on each wing, they explained consistent regular staffing would benefit people at the home living with dementia. A staff member told us that they were more familiar with people on a different wing in the home and when working with people they were less familiar with they had to learn quickly about people's preferences. They said, "People [on the dementia wing] don't like strangers, they panic and become agitated and unsettled and then it leads to incidents, shouting at each other, shouting at staff. They don't like people that rush around but we have to rush.".

● Staff told us they were often unable to provide consistent, effective and timely care because of staff deployment, a senior meeting was meant to take place to help improve the deployment of staff and provide consistency on each unit. The meeting did not take place. During the inspection some staff lacked knowledge about what care people had received. A relative told us, "I asked the nurse and she doesn't know, she told me to ask the carer [Name], but [Name] doesn't know, when I ask different carers about my concern they just say it's okay.".
● People's healthcare needs were monitored and supported through the involvement of a range of professionals including GPs, district nurses and therapists.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's care records contained a full initial assessment of their needs which was carried out before the person moved into the home. Assessments were undertaken by either the manager, or a senior member of staff.
● Care plans contained sufficient detail and included information obtained during the initial assessment.
● Care plans were reviewed regularly. Staff told us that there had been historical issues where information within people's care plans was not reflective of their needs. Managers told us that a review of all care plans was underway to rectify this.

Staff support: induction, training, skills and experience
● All staff were provided with an induction when they began working at the home and completed the care certificate. The care certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job role in the health and social care sectors.
● Staff were provided with ongoing learning to ensure they could meet the needs of people living at the home. Records confirmed that compliance for mandatory training was good.
● Some staff told us that they had not had training relating to catheter care and challenging behaviour and felt that they would benefit from more knowledge in this area.

Adapting service, design, decoration to meet people's needs
● There was a noticeable lack of directional signage to promote peoples independence moving around the home. There was some use of colour contrasting on the doors of people's bedrooms, but these were mainly pastel and didn't stand out against the neutral corridor walls. There were memory boxes outside people's bedrooms to orientate people to their personal space but many of these were empty.
●The home was very modern and provided good facilities. Living and dining areas were spacious and on the first floor a purpose-built outdoor balcony area which was safely enclosed provided a pleasant outdoor space for people living on the first floor. The garden area outside had a large patio space for people to relax and enjoy the views of the well-tended garden.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).
●We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. We found they were working in line with the principals of the MCA.

● Records relating to the administration of covert medicines did not include evidence of best interests' meetings being carried out. It is important to ensure that where a person lacks capacity and is unable to decide about their health, that there is clear evidence of who was involved in making the decision and why it was deemed to be in their best interests.

● Records showed that staff had been provided with training relating to the MCA and DoLS.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement.

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

Ensuring people are well treated and supported; respecting equality and diversity

● People and relatives told us individual members of staff were kind and compassionate, but the providers failure to deploy sufficient staffing meant staff did not always have time to care for them in a person centred way. One relative said, "The staffing levels are our main concern. We've no concerns about the carers themselves; the regular carers are very caring. It's just there aren't enough of them." Another relative told us, "When [my relative] first came here there were enough staff , but they've reduced since then and now there aren't enough. When we raise it we're told there's enough staff for residents' care plans.".

● Where staff were able to focus on people's needs we saw positive interactions between staff and people. A person was being assisted to eat lunch in their room, we observed staff describing the meal, enquiring as to the temperature of the food and whether the person was enjoying it. The staff member provided gentle reassurance and coaxed the person gently to eat and plenty of time was given to finish each mouthful. The person had a specific care plan describing how they need assisting to eat which was displayed on the wall of their bedroom. The staff member followed these guidelines.

Respecting and promoting people's privacy, dignity and independence

● Staff did not always have time to stop and acknowledge people properly. We observed occasions where people were attempting to gain staff attention and staff would rush by. People's dignity was not maintained consistently because people did not have the personalised support they required. We observed one person in bed, who had food stains on their clothing from breakfast, their night catheter was still attached and visible from the corridor. Another person's dress was riding up which staff did not respond to and another person had spilled food all over their chair and had fallen asleep at the table.

● Staff were observed to be discreet when people needed assistance and sought consent where residents required support with personal care. When communicating with people staff were overheard saying, "Can I help you with that?" and "Are you comfortable?"

● When bedroom doors were closed staff were observed to knock and identify themselves on entering the room.

Supporting people to express their views and be involved in making decisions about their care

● People and relatives expressed their frustration in relation to the lack of response they received from the provider when making suggestions about their care. One relative said, "It's almost as if they don't want you to ask questions. My [relative] needs exercise which I'm prepared to pay for and I've asked for information on private exercise providers. I've asked three different people now, but no one's come back to me. They took

away [my relatives] shower chair to give to another resident who was in greater need of it, but they didn't replace it and [my relative] being washed in her chair. I complained, but nothing has happened and when I made another complaint the manager said to me, "Maybe you'd like to go somewhere else."

●Records showed that where possible people had signed their care plans to confirm that they had been consulted and were in agreement with the care they were receiving.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Outstanding. At this inspection this key question has now deteriorated to Requires Improvement.

This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● Throughout this report we have identified several ways in which staffing shortages and deployment resulted in people receiving frenetic task orientated care which didn't meet their own specific needs. On the second day of inspection just before lunch, we spoke with one person who said, "Oh yes they've been to move me but I've not had personal care today yet.". We noticed that the person still had their catheter attached from the previous night and it had not been emptied.

● Relatives expressed concern about staffing at weekends, one relative told us, "There's poor staffing on the weekend. I came in two weeks ago I found [my relative] stuck in their wheelchair saying there was no one to take them to the toilet. I've found [relative] alone in the dining room after 2pm with no buzzer which isn't safe." The went on to say, "I asked for one (a remote buzzer) at the beginning of the year, but nothing's happened. Two years ago, there were two carers and a senior on each section, but that's been reduced since then. If I didn't come in every day I wouldn't be sure who will help [relative] eat. I'm going away soon and I'm not sure that they'll be ok while I'm away; that they'll feed [my relative] properly and take them to the toilet."

Improving care quality in response to complaints or concerns

● Some people and relatives told us that complaints and concerns do not always appear to be taken seriously and when complaints and concerns are expressed, nothing seems to change or improve. One relative told us, "When [relative] first came here there were enough staff , but they've reduced since then and now there aren't enough. When we raise it we're told there's enough staff for residents' care plans.". A person living in the home told us, "It seems that people who have complained are shunted away."

● People and relatives were aware of how to raise complaints and concerns, but some relatives we spoke with did not know about the most recent changes to the management of the home and therefore were not aware of who to raise concerns with.

● The provider facilitated meetings for people and their relatives. Some relatives said that recent meetings had not been productive. One relative said, "[Former activities coordinator] led the last meeting which wasn't their job. They got stressed with all the other things they were being asked to do and left."

● One relative we spoke with was happier with the communication between them and the managers and told us, "They're very good at keeping us in touch with what's happening."

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

● The provider employed an activities coordinator and a schedule of weekly activities were organised for

people each day. A dementia café was advertised as being held on Fridays and there were other events organised by external agencies including exercise sessions and 'Singing for the Brain'. A hairdresser was based on site for people living in the home.

● On the first day of the inspection we observed a singalong session, knitting and flower arranging were scheduled. During the morning we observed people taking part in a singalong session and saw children visiting people in the downstairs lounge. During the afternoon we observed one resident in the same lounge engaged in a knitting session with the activities coordinator.

● One person spoken with said that they had been a church organist and the home had both a piano and an organ which they enjoyed playing. Another person said, "I enjoy the exercises." Another said, "There was an RAF flypast on Saturday with everybody outside which was lovely".

Meeting people's communication needs

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

● The provider told us that they were able to provide people with information in a format that was accessible to their needs, for example large print or audio.

End of life care and support

● During the inspection visit no people were at the end of their life. Do not attempt to resuscitate (DNAR) records showed that reasons for decisions were clearly recorded. We noted that the records for one person showed that the person had been assessed as not having capacity. Their relative who had power of attorney (POA) for health and well-being had been involved in the decision, and an end of life plan had been developed to show how they thought their relative would wish to be supported at this stage of their life.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- When we inspected the service the home had been without a registered manager since January 2019. There was also no deputy manager in post, however the provider had successfully recruited a deputy manager who was due to commence their role in June. The provider had transferred an experienced manager from another home and assured us that they would remain at the home until a suitable long-term replacement had been recruited. We were assured that an application to register the acting manager would be made without delay. At the point of writing this report the application had not been made.
- Turnover of managers during the previous 12 months had been very high. We noted that the previous manager did not make an application to register with us and left after a short period of approximately six weeks. Prior to this, three other managers had left the organisation during the previous 12 months. People and relatives were concerned about such frequent changes of the manager. One relative said, "Nobody tells us what is going on, I can't believe another manager has left, just when we thought we were getting somewhere."
- Staff described their frustration and concern about the turbulence caused by repeated changes in leadership and the impact this was having upon morale within the home. One staff member said, "It has been a rollercoaster 12 months. Not having a consistent manager in place has caused so many problems. There is a lack of structure and the DICE tool (staffing calculator) doesn't work and there are aren't enough staff. Just when you think you are getting somewhere the manager leaves without explanation. We have been told that the cause of staff levels is because care plans are not up to date, and we have to update them, but we are not being given the time to do it as we are rushed off our feet."
- Systems and processes to monitor the safety and quality of the service were ineffective and did not identify the concerns we identified during this inspection. We noted that the provider had been aware of some shortfalls and following a Local Authority contracts visit earlier in the year and had been working on an action plan to address these. However, risks we identified such as pressure ulcers, choking and dehydration had not been identified during regular themed audits carried out by previous managers.
- The provider did not adopt a culture of continuous learning to improve care and safety. We were concerned that problems had been identified such as insufficient staffing levels, choking and dehydration were identified when we inspected another care home owned by the same provider in February 2019. The lessons learned from the shortfalls were not shared across the organisation and known issues regarding very similar themes were not reflected and acted upon.

The above concerns demonstrated a failure to ensure effective systems and processes were deployed to monitor and assess the quality and safety of the service and was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

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

● As described throughout this report insufficient staffing levels have hindered the providers ability to provide good quality, safe care to people. The lack of consistent leadership has exacerbated the problem and reduced the providers ability to develop a culture that is person centred, open, inclusive and empowering. We saw isolated examples of care delivered by staff which was person centred, but this was counteracted by observations of task centred, rushed care being delivered by a staff team who were frustrated.

● Staff consistently told us that the morale in the team was low. To their credit, the staff we spoke with were candid in their feedback of working in the home, in particular the senior care staff who demonstrated a commendably open and non-defensive approach, despite the many areas of concern we identified during our inspection.

● Staff told us that support for their wellbeing had been overlooked by the provider during the last 12 months and that although supervision meetings and team meetings had taken place for some staff this had been sporadic and ineffective.

● Following our inspection we met with a senior operations director and the nominated individual. We were assured with the suggested measures taken by the provider to improve the safety of people living at the home. However, we were less assured staffing levels would be increased immediately to reduce the pressure on the staff team, despite the consistent concerns raised by people, relatives and staff. We were told that the issues within the home were not solely attributable to a lack of staff and that contributory factors such as culture and leadership required improvement to ensure that people's needs would be met in the future.

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 attitude of the regional director and the acting manager was positive throughout the inspection. We fully acknowledged such a high turnover of previous managers had reduced their ability to establish why shortfalls had occurred, but this did not affect their willingness to assist and support the inspector and the inspection team.

● The provider understood their regulatory requirements and consistently ensured that they notified us about events that they were required to by law.

● Our previous inspection ratings were displayed prominently on a notice board in the reception area of the home.

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

● Staff had developed professional relationships with a range of health and social care professionals.

● Feedback we received from health and social care professionals prior to and after the inspection visit expressed similar concerns regarding the providers approach toward staffing levels and safety. However, comments were positive about the providers willingness to improve.

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 Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider's failure to ensure people's nutritional and hydration needs were properly met and monitored was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The above concerns demonstrated a failure to ensure effective systems and processes were deployed to monitor and assess the quality and safety of the service and was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The providers failure to ensure that risks were mitigated to ensure peoples safety placed people at risk of avoidable harm. This was a breach of regulation 12 (1) (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

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Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Peoples needs were not being met due to insufficient levels of staffing. This placed people at risk of harm. This was a breach of regulation 18(1)(Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Warning Notice