Bondcare (London) Limited

Fern Gardens Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Fern Gardens Care Home is a nursing home for up to 92 older people. The service was previously called Coniston Lodge Nursing Home. The service is managed by Bondcare (London) Limited. At the time of our inspection 50 people were using the service. Some people were living with the experience of dementia and some were being cared for at the end of their lives.

People's experience of using this service and what we found
People were not safely cared for. The provider had not always assessed, monitored or managed risks. The staff had not always responded appropriately to accidents and incidents and there were not always investigations or analysis to find out what happened and learn from these.

Medicines were not always safely managed. There had been recent improvements to medicines management following serious concerns raised by a visiting healthcare professional and safeguarding investigations. However, these improvements were not enough to ensure this was safe.

There had been multiple safeguarding concerns in 2021 with some recurring themes of poor care, poor medicines management and avoidable falls. The investigations into these by the local safeguarding authority found that, in many cases, the provider had not protected people from abuse and had sometimes failed to follow their own safeguarding procedures.

There was a poor culture at the service, where people using the service, their representatives and staff expressed concerns about management, care and support. Some staff had raised concerns which had not been responded to and they felt unsupported. The staff teams did not always communicate well with each other and this had a detrimental impact on people's care.

People were not always treated with respect and their needs were not always assessed, planned for or met. For example, care plans were incomplete and did not always give guidance on how to meet people's needs in a personalised way. Additionally, records of care provided indicated gaps in people's care. This was confirmed by some relatives, who explained people's basic needs were not always met.

However, some people were happy with the service and explained that some of the staff were kind and caring.

The provider had identified widespread concerns about the service and had developed plans to try and address some of these. The manager was absent from the service, and the acting manager, who had been in post for a few weeks, had started to make changes. Staff spoke positively about these changes and the acting manager.

Following our inspection, the provider supplied us with further information about improvements they

intended to make.

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 inspection of the service was a targeted inspection where we looked at a specific area and did not assess any key questions. Therefore, a rating was not awarded.

The last rating we awarded was Requires Improvement (published 4 February 2021). From January 2020 until January 2021 the service had been in special measures. We found improvements at our inspection of November 2020 and special measures were removed following that inspection. However, at this inspection we identified multiple breaches of regulations and found the improvements had not been sustained.

Why we inspected
The inspection was prompted in part due to concerns received from a high number of safeguarding alerts where the provider was found to have neglected people and put them at risk. Some of these concerns included medicines errors, falls, unexplained injuries and care needs not being met.

We also received concerns from whistle blowers, relatives and visiting professionals. These concerns included failure to report concerns to others, respond to these and about poor care.

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, caring, responsive and well-led sections of this full report.

We reviewed the information we held about the service. No areas of concern were identified in the key question of effective. We therefore did not inspect this key question. Ratings from previous comprehensive inspections for this key question was used in calculating the overall rating 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.

The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.

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

We have identified breaches in relation to person-centred care, dignity and respect, safe care and treatment, safeguarding people from abuse and improper treatment and good governance at this inspection.

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

Follow up
We will meet with the provider to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Fern Gardens Care Home

Detailed findings

Background to this inspection

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

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 conducted by three inspectors, a member of the CQC medicines team and a nurse specialist advisor. An Expert by Experience supported the inspection by contacting the relatives (and friends) of people who used the service the day after our visit. 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
Fern Gardens Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The provider is required to have a registered manager at the service. There has not been a registered manager at the service since January 2020.

A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed all the information we held about the service. This included safeguarding meeting minutes and alerts, records of complaints, whistle blower alerts, notifications and information from the provider. We spoke with visiting professionals from London Borough of Hounslow, the community matron and the local safeguarding team.

The week preceding our inspection, we were contacted by the relatives of two people raising complaints and two members of staff also raising concerns.

During the inspection
We spoke with nine people who used the service and two visiting relatives. We observed how people were cared for and supported. Our observations included 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 met with staff on duty and spoke at length with 12 care workers and senior care workers, two agency (temporary) staff, three nurses, the activities coordinator, the deputy manager, acting manager and senior managers based at the service.

We looked at a range of records including the care plans and associated records for 10 people,15 people's medicines records, records of accidents, incidents, five staff files and other records used by the provider to manage the service, which included audits and meeting minutes.

We conducted a partial tour of the environment, including looking at infection prevention and control processes and looked at how medicines were being managed and stored.

After the inspection
We contacted 54 members of staff to ask if they wanted to share any feedback about their experiences and received feedback from three.

We spoke with the relatives and friends of 12 people who used the service.

The provider continued to send us information, which included evidence of staff recruitment checks, audits and their action plans to address some of the concerns we had identified.

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.

Systems and processes to safeguard people from the risk of abuse

● People using the service were not always protected from abuse. There had been multiple safeguarding concerns, which when investigated by the local safeguarding authority were substantiated. These included examples of poor care, medicines errors and preventable falls. Investigations into some of these concerns identified that staff had given false information about what had happened and had also falsified records. Staff told us some managers had asked them to do this. Safeguarding investigations also confirmed this.

● Two relatives who contacted CQC shortly before the inspection told us people had expressed concern about the staff reaction towards them. For example, they were scared staff would 'not like it' if they shut their bedroom door to have a private conversation with their relative. One of the relatives told us their relative was scared of other people because they could be aggressive, and they felt this wasn't well managed. We witnessed people being loud and saw evidence of aggression towards staff and other people within incident reports. During the inspection visit, one person told us that items went missing from their room. Relatives also confirmed this, and this had been the subject of a safeguarding investigation.

● The staff told us they were not made aware of the outcomes from safeguarding investigations and whether protection plans were in place. Comments from staff included, ''We don't really know how many safeguarding cases there are. They don't tell us the outcome or what happened'', ''We would like to know the outcome so we could prepare for next time and what we should not do'' and ''It is never mentioned if there has been an investigation. Sometimes I notice changes, like getting called to emergency training, but they don't tell us why.'' Failure to discuss these issues with staff may result in reoccurrence because they do not understand what has gone wrong.

● One incident report included a record where staff described how they had physically restrained a person by holding their arms. The use of physical restraint should only be carried out by staff who are trained to do this and understand about safe techniques. The staff had not received this training. There were no records to show this restraint had been investigated or reviewed to make sure it was appropriate and did not cause unlawful restrictions of the person. Furthermore, the incident report stated two other people were physically assaulted by the person. There was no investigation into this, and no safeguarding alert had been made. We raised this as a safeguarding concern with the local authority so they could investigate.

The provider did not effectively operate systems and processes to protect people from 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.

● Some people told us they felt safe at the service, and their relatives also said this. Their comments included, ''I think [person] is safe, but there are a lot of things in the way [they] are cared for that are less than good'', ''[Person] was verbally abused by staff, but that staff no longer works there'' and ''I feel safe.''

Using medicines safely

● Medicines were not always safely managed. The visiting community matron raised concerns about poor management of controlled drugs, problems with administration and record keeping. Although the provider had recently implemented systems for ordering, administering and monitoring medicines we found several discrepancies between medicines administration records (MAR) and medicines people were receiving. For example, one person's MAR chart stated that they were prescribed a dose of 0.5mg of a psychotropic medicine a day. However, records stated they had been receiving 1mg of this medicine instead.

● People did not always receive their medicines as prescribed. We looked at 15 MAR charts and found several discrepancies, which did not provide a level of assurance that people were receiving their medicines safely, consistently and as prescribed. For example, two people were prescribed medicines for Parkinson's (a neurodegenerative condition) which needed to be taken at a specific time in order to have the intended benefit. Records did not clearly state the time these should be administered or when they had been administered each day. One person in receipt of this medicine expressed a concern about this having an adverse effect on them. Furthermore, on the day of inspection we observed that two of the three medicines rounds in the morning finished at least two hours after the time indicated on the MAR charts, meaning that the provider could not guarantee people had received their medicines at the right time, or that there were sufficient gaps between doses of some people's medicines.

● Records for topical application of medicines were not always completed accurately. There were separate charts for people who had medicines such as patches and insulin prescribed to them to show the site of application. The majority of these had been completed. However, we found that a patch application record for a pain medicine had not been completed accurately for one person. Body map application records had not always been completed for people who had prescribed creams (e.g. creams for an infection) to indicate the site of application. Failure to record accurate administration of these medicines meant we could not be assured these medicines had been applied safely for people.

● Whilst medicines were stored securely, we found that staff were not always recording that they had checked the temperature of storage areas. One medicine that should have been in the fridge was found in the medicines trolley instead (stored at the wrong temperature). This meant that we could not be assured that all medicines had been stored safely, in line with the manufacturers' instructions.

Failure to manage medicines in a safe way placed people at risk of harm and was a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following negative feedback from visiting professionals and substantiated safeguarding concerns about medicines management, the provider had started to address some of the concerns in this area. They had introduced a new system to monitor and audit people's medicines on a regular basis, and we found improvements had been made as a result of this. For example, the latest monthly audit by the manager and clinical lead identified a need to complete PRN (as required) protocols for each person and these had been done in a timely manner.

Learning lessons when things go wrong

● The provider did not always have systems for learning when things went wrong. For example, there were records of incidents which had not been analysed by managers and there was no learning from these. This was also the findings from multiple safeguarding investigations, where staff had not followed correct procedures or monitored people's wellbeing following an accident or injury.

● Records of incidents from May to July 2021 included examples of staff being injured when supporting people. Additional incidents of this nature were also recorded on the electronic care planning system. These included incidents where staff had been hit, scratched and had their hair pulled. In one incident a person held a staff member by the neck. There were no records to show staff had received support or taken part in

reflective practice following these or had the training needed to understand and manage these situations. Some staff confirmed they had not received this, stating they were regularly scratched and spat at but that they did not have opportunities to talk about or be supported with this.

● The care plans and risk assessments for some people who were aggressive were not detailed enough to ensure staff had the guidance they needed to safely support people. For example, one person's care plan stated, ''Tends to wander around the unit but does not display any challenging behaviour.'' However, records of their care contained nine incidents in August 2021 which included damage to property, throwing items at staff, shouting at staff and other people, hitting and 'fighting' staff. The incident where a staff member was held by the neck happened in June 2021. Nevertheless, this person's care plan had been reviewed and updated seven days later with the same outcome stating the person did not display any ''challenging behaviour.'' The planned interventions for supporting this person did not take account of any of the types of incidents described, how to prevent these or how to manage the situation if they did occur. The care plan referred to a specific type of care intervention which staff would need to be trained in. They had not had this training.

● Incident reports included language and terminology used by staff which demonstrated a lack of understanding about people's needs and how to support them. For example, one incident report described how someone had become aggressive towards staff. The staff had recorded, ''Staff insisted [person had] a shower.'' The incident report did not include any plan or review of whether it had been appropriate for staff to ''insist'' the person had a shower. Another incident report described how staff had ''walk[ed] up to [person] and [they were] already in a bad mood.'' Describing someone as in a 'bad mood' indicated a lack of understanding about their needs. There was no reflected practice following this or update to show a manager had reviewed this information.

● There was evidence of analysis following a small number of incidents. Although these records showed fault had been found, they did not always include learning from them. For example, there was an incident where the safeguarding authority found staff had not followed correct manual handling or post falls protocols in May 2021.We saw the staff had met with their line manager to discuss this. But records of these meetings did not include any agreed actions and there was no recorded follow up, training, monitoring or disciplinary action in their files nor was there any evidence of further supervisions to discuss whether they had learnt from this incident. The provider has told us they disagree with the findings of the safeguarding authority regarding this incident.

Failure to provide effectively manage these risks was a further breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 .

● The acting manager had been in post for three weeks at the time of our inspection. They had started to assess and reflect on things that had gone wrong. They had produced a plan to address some of the themes from safeguarding alerts, incidents and other concerns. This was a positive step, although the systems had not been embedded at the time of our inspection.

● The provider had supplied staff with updated training and guidance following some incidents. For example, in June 2021 they identified staff did not follow safe arrangements for supporting people in the event of a fire drill. We asked staff about their understanding in this area and they were able to demonstrate a good knowledge of the correct procedures.

Assessing risk, safety monitoring and management

● People were not always kept safe. During the inspection, we met a person who was walking into one dining room. The person had walked from another unit through the garden wearing just their socks. They had been provided with anti-slip socks, but these were twisted around so did not provide the required protection. A member of staff offered to escort the person back to their unit but needed to be told by the

inspection team that the person could not walk through the garden in socks and that the socks were twisted and needed to be adjusted. They had not adequately recognised the risks for this person. Over two hours later we met the person again. They were not being supervised by staff and had to hold onto an inspector to steady themselves, their socks remained twisted.

● Risks had not always been managed safely. One person was nil by mouth (meaning they were at risk if they were given food or fluids). This was confirmed in their care plan. However, their nutritional care plan included the instructions they should be given, ''At least two nourishing drinks, snacks and a fortified drink.'' If staff followed this care plan the person would be at risk of harm. Many of the staff providing care were agency (temporary) staff who did not know this person. The records of care for 8 August 2021 stated the person, ''had a glass of water and drank 265ml.'' This intervention placed the person at risk. There were no records to show this had been investigated or whether the person had been checked following this to make sure they were safe and well. We alerted the local safeguarding authority to this concern

● For one person who had a wound, the visiting tissue viability nurse had recommended dressings were changed every three days. The only recorded changes of dressing since 31 July 2021 were on the 31 July and the 8 August 2021. Additionally, the pressure relieving mattress they used had not been correctly maintained, as it was not always set at the right pressure or checked. Therefore, the person was placed at risk of further skin damage.

Failure to provide care and treatment in a safe way was a further breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

● We saw staff providing safe care and support to people who were eating and drinking. They followed guidelines and made sure people were positioned safely, had the right texture of food and fluids and were given the time they needed.

● The provider was renewing training about skin care and treating wounds.

Preventing and controlling infection

● The provider had not always taken the necessary steps to prevent and control infection. Since the start of the COVID-19 pandemic staff in care settings have been required to wear masks to help prevent the virus spreading. Throughout the inspection, we observed some staff, including managers, were not wearing masks, some wore loose fitting masks which slipped below their noses and some wore masks hanging around their ears or below their chins. These was also the findings from a local authority audit in June 2021. The community matron told us they found staff did not always wear masks during their visits to service. We discussed this with the management team. We were assured the staff knew what they were supposed to be doing but this bad practice presented a risk of them spreading infection.

● The service was clean and well maintained during our inspection, although some equipment needed to be deep cleaned and one person reported, and showed us that, staff had left a used continence aid in their laundry basket. Some staff told us they did not always have access to supplies they needed to wash people and also told us about bad practice where other staff did not use soap when washing people because they were rushing. Following receipt of the draft inspection report, representatives of the provider told us this was not true.

Failure to have systems to prevent and control infection was a further breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had introduced updated procedures in order to manage during the COVID-19 pandemic, these included regular testing for people using the service, staff and visitors. Some concerns had been raised before the inspection, by visiting families and professionals about testing, but the acting manager had

addressed these and people using the service, their families and friends told us arrangements were now suitable.

Staffing and recruitment

● There were enough staff to meet people's needs, and the provider used a dependency tool to assess this. But, some people told us staff were rushed and did not provide care when they wanted and needed this. Some staff also commented on this, telling us they did not have time to provide care. However, when we spoke with them further this seemed to be related to poor communication between staff teams, including inappropriate allocation of work by shift leaders. For example, staff being told they had to wash a specific number of people within a certain time, so they did not have time for quality interactions. Additionally, some staff told us other staff (particularly at night) did not carry out their work. One staff member told us other night staff sometimes did college work or used their phones and laptops instead of supporting people. We have shared these concerns with the provider so they can look at ways to address these. The acting manager told us they were going to increase night-time audits.

● There had been periods of staff shortages, with absences and vacancies covered by agency (temporary) workers. This was still the case some of the time. The acting manager told us they tried to get the same familiar agency workers to help provide consistency.

● The provider had suitable systems for recruiting new staff, including checks on their suitability. We found some records were not in place within staff files at the time of the inspection visit. However, the provider sent us the missing information after our visit.

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 requires improvement. At this inspection this key question has remained the same. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- People were not always treated with respect or well supported. One person told us the night staff washed them in the early morning and then put them back to bed. They said they did not want this but ''[The staff] do not listen to me.'' We were contacted by a member of night staff who told us there was an expectation by shift leaders that they washed as many people as they could before the day staff arrived. They also said some other staff tried to rush this by using just water, with no soap, to speed up the process. This kind of practice does not take account of people's personal preferences or treat them with respect.
- Some people told us about experiences which showed they were not always respected. Their comments included, ''The carers are sometimes nice. Some treat me wrong, some are nice and some are not'', ''I hate the back chat from staff'', ''They are sometimes disrespectful'', ''Some of the staff are good but you have some who come in and think they are running the place'', ''Staff used to be alright, but now they don't have the time, you ask them something and they tell you, 'later''' and ''I have to wash myself so I wouldn't bother them, they don't help .''
- People did not always feel their privacy and dignity were respected. They told us sometimes lights were left on in their bedrooms at night and staff did not always introduce themselves before providing care.
- Staff told us that there was sometimes poor communication within the staff teams. We witnessed this having an impact on one person's experience when they were made to wait for lunch because the staff could not agree on what to give them. At one point, a staff member tried to give them someone else's lunch in order to resolve the situation, but they failed to recognise this left the other person without their meal. In another example, a member of staff was assigned to provide individual care for a person. The member of staff told us the name of the person, but this was not their name. They were not able to tell us anything about the person or why they had been assigned to give individual care.

Failure to make sure people were treated with dignity and respect at all times was a breach of Regulation 10 (dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Some people and their relatives commented positively about staff. One person told us, ''Some of the staff are very kind and caring.'' We also witnessed kind and gentle interactions where staff were supporting people. Some staff knew people well and laughed, joked and chatted with them.
- The provider had started to provide basic care training for staff to help them to understand what was important when providing personal care. The provider's trainer spoke with us about this, telling us the

training addressed communication, respect and offering choices as well as other ways to deliver good quality care.

● We saw staff respecting people's choices during our inspection. Records, such as care plans, did not always show people were consulted or had made choices about their planned care. The acting manager had identified this as an area where improvements were needed and had a plan in place to address this, which included workshops for staff, auditing records and updating care plans. This is addressed in more detail in our report under the key question, 'Is the service Responsive?''

● People were supported to be independent where they were able. For example, if they wanted to manage their own personal care, moving around the home independently and having meals without assistance. People were not rushed when they wanted to do these things during the day.

Inadequate

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

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

- People's needs were not always being met. We identified one person had long toenails which needed cutting. Relatives of other people also commented about this being a problem, along with people's hair needing cutting, ears needing cleaning, people needing a shave and people not being washed properly. Failure to meet basic care needs had been identified in a number of safeguarding investigations. Some comments from relatives included, ''[Person] is left in [continence pads] for a long time and these are not changed as often as they should be'', ''Last time I visited [person] hadn't been shaved for a few days, [their] hair was long and they looked scruffy'', ''We have had to tell them that it is undignified for [person] not to be dressed in [their] preferred traditional dress'', ''For a while [person] looked a bit unkempt, hair was too long, toenails neglected'' and ''When they get [person] up, [they] slump, sometimes the staff support [them] with cushions, but not always.''
- Care plans were not always in place when needed. One person who had moved to the service eight days before out inspection had high needs including diet-controlled diabetes. There were no care plans or assessments in respect of these needs and the nutrition care plan did not mention they had diabetes. The person's discharge summary from hospital also reported they had pain and used a frame for walking. There were no mobility or pain care plans for this person.
- Another person's care records stated they had epilepsy (a condition where people experience seizures). There was no care plan in place in respect of this condition, to explain how they presented when having a seizure or what staff should do to support them and keep them safe. Their care plan also listed other medical conditions, which included schizophrenia (a long term mental health condition causing delusional thoughts), stroke and a history of drug use. There was no guidance or care plans for staff on how to support this person with these needs or how to keep them safe.
- A third person received nutrition and medicines through a PEG (percutaneous endoscopic gastrostomy). This allows nutrition, fluids and medicines to be put directly into a person's stomach. Care plans for this person did not included enough detail to ensure safe care would be given. For example, the care plan did not state how much fluid was needed with medicines or how to prevent infection.
- Care records and plans were not always clear, detailed enough or accurate. For example, some of the care plans included other people's names and it was not clear whether this was just an error with the names or whether the wrong needs had been recorded. Care notes did not show whether care had been given as planned. The records of care provided to one person who required nutrition through a PEG did not record any nutritional intake for three days in August 2021. Records indicated staff did not always support people with oral care. For example, one person had not received oral care for 12 of the last 17 days, one person for five of the last eight days and a third person had no recorded oral care for 20 days in a one month period from June to July 2021. Their care plans stated they should be supported with oral care twice a day.

Failure to provide personalised care which met people's needs and reflected their preferences was a breach of Regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The acting manager had identified care plans needed to be improved. They were in the process of auditing these and had created action plans for the areas where improvements were needed. Care plans were stored on an electronic system and staff used handheld devices, so they were able to read and view these when providing care if they needed to check information.
● The acting manager had also analysed feedback from safeguarding outcome meetings, audits and other concerns to find out where care needs were not being met. They were working with staff and the provider's trainer to improve practice.

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 staff had created communication care plans, although these were not always detailed enough to show people's individual and personalised needs. One person told us their hearing aid was broken and they could not hear properly without this. Furthermore, relatives of two other people told us that, despite people requiring hearing aids, they were regularly not given these, which increased their frustration when communicating.

This was a further breach of Regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

● Staff spoke a number of different languages which meant they could communicate with most people in their first language.
● The staff used a communication book to help them communicate with one person who had speech problems.

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 made arrangements to support people to take part in social activities. Some relatives raised concerns about the variety of social activities on offer, in particular for people who remained in their bedrooms. The provider employed two activity coordinators and they arranged for group and individual leisure activities. We saw a small group of people participating in music and exercise sessions. The activities coordinators told us they created a plan (which was displayed) but the said that in reality, people made choices about the activities each day. They said this worked well for some people, but we found others felt improvements could be made to cater for their needs.
● Two relatives told us that although people were known to enjoy the television or radio, staff often forgot to turn this on. One visitor told us the person's room had been rearranged making it difficult for them to view their television and their television was broken. These visitors had raised the concerns with staff so they could address these issues, however, one visitor contacted us again a week after the inspection to tell us the person's television remained broken.
● People, their relatives and friends told us that restrictions on visiting imposed by the COVID-19 pandemic had been reduced and they felt happier that visits were allowed to take place and people could meet visitors in their own rooms.

End of life care and support

● Some people were cared for at the end of their lives. The acting manager had identified care plans were not always clear or accurate about people's wishes in this respect and they were trying to improve these. They had an action plan outlining where improvements were needed.

● The staff worked with palliative care teams and other professionals to make sure people received the medicines and care they needed to be comfortable and pain free. Some staff told us they had not had specific training about end of life care and would benefit from this to help their understanding and knowledge.

Improving care quality in response to complaints or concerns

● The provider did not always have robust arrangements for acting on people's complaints. People who contacted us before the inspection told us they had made complaints, but these had not been dealt with. For example, one person made a complaint to the provider early in 2021 and again in March 2021. When they did not receive a satisfactory response, they contacted CQC who raised a safeguarding concern. The allegations were later substantiated by the local safeguarding authority. Another relative told us they had raised concerns in April 2021, but these had not been responded to. A third relative raised a concern with a member of staff in May 2021. This was later investigated under safeguarding processes and substantiated. The outcome for the safeguarding meeting described how a care worker and nurse who were aware of the complaint, had not alerted the management team to this meaning the complaint had not been investigated.

● The acting manager had been in post less than a month at the time of the inspection, they could not locate any records of complaints, so it was difficult to assess how many other people had raised concerns and how these had been dealt with. However, one relative told us they had made a complaint in 2021 and they were satisfied with the response.

Failure to have robust arrangements in place to act on complaints was a breach of Regulation 16 (receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had a suitable complaints procedure and the acting manager knew this and how to respond to future complaints. Some relatives had told us they were concerned about speaking up and we let the management team know this, so they could enable people to feel confident complaints would be dealt with without adverse consequences.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

● There was a poor culture where people using the service and staff did not always feel safe or empowered. One person told us, ''There is nothing good about this home.'' Another person said, ''It's been pretty poor in this place.'' A visitor explained during their last visit a person had, ''Held their hand and said, 'please get me out of here.''' Comments from some of the staff were equally unsettling with some staff crying as they spoke with us. One member of staff told us they did not feel safe.

● Prior to the inspection, some staff had made allegations about how they were treated by their line manager to senior managers. They told us they had not been listened to or respected. One member of staff said that when they raised concerns with a senior manager, they were asked whether the manager's behaviour had just been a joke. They also said, ''The managers told me if it had been just me (making the complaint) they would not have believed me.'' The provider only responded fully to these concerns when staff approached CQC and we wrote to the provider. They were investigating the allegations at the time of our inspection. But during the inspection, staff told us senior managers had not checked up on their wellbeing or apologised for what had happened. Some staff also told us they had alerted Bondcare managers to other concerns in the past and these were not dealt with. One member of staff said, ''I have been made to think I am wrong and a troublemaker (for speaking up), when I have raised things they have been brushed under the carpet.''

● Staff told us they had witnessed a manager shouting at other staff. They had also had their confidence breached when they raised concerns, and these were discussed with other staff at the service. Staff told us there was poor communication with each other and a culture of blame. A relative told us they had heard staff having a ''screaming match'' in the corridor. The relative was able to share detailed confidential information with us which they should not have known but they had heard because this had been part of the staff argument.

●Safeguarding outcomes for a number of concerns identified staff had falsified records and statements about what had happened. Some staff told us that there was still poor practice which went unchecked, particularly at night. One staff told us night staff regularly falsified records such as repositioning charts and records to say care was provided when it wasn't. The provider's representatives denied this.

● The acting manager showed us plans to address some of the issues which they or others had identified before the inspection, however not enough improvements had been made. For example, safeguarding outcome meetings and feedback from a visiting healthcare professional had identified poor wound care. The acting manager had a plan to address this failing, however, on the day of our inspection we found one person's wound care plan was not being followed and equipment they used to prevent further pressure

sores was not checked or correctly maintained. Another area of improvement which had been identified was for better oral care. However, three people's care records we viewed showed oral care plans were still not being followed.

● There had been a significant number of safeguarding concerns which showed people had received poor care. We found that despite the provider being involved in discussions following safeguarding meetings where protection plans were discussed, people were still not safe, because risks had not always been assessed or managed and medicines were not always safely managed. Care plans were not detailed or accurate enough and people's care needs were not always being met.

● In January 2020 we imposed conditions on the provider's registration requiring them to share monthly audits and action plans with us. However, the level of concerns we identified at this inspection dated back over several months and indicated these audits were not sufficient and the provider had failed to meet their own plans for improvement.

Systems and processes had not been operated to ensure a good quality service and this was a breach of Regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Since the acting manager came to the service a few weeks before our inspection, they had started to make changes. They were analysing safeguarding information, concerns and using their own audits to develop an action plan. Improvements included providing intensive training for the staff about meeting basic care needs and improving medicines management.

● Following the inspection, we shared some of the feedback we received from staff with the provider. They told us they would arrange for better support for the staff team to discuss some of their concerns. They also acted on concerns raised by one person and subsequently made a safeguarding referral to the local authority. One senior manager told us support had been offered to individual staff before the inspection. Whilst the provider felt they had offered some support, we found they had not successfully managed to alleviate staff fears or enable staff to feel supported, because we received a consistent message from staff which demonstrated this.

● The provider had started to undertake a range of audits. These had helped to identify where improvements were needed. There were action plans for each of these recent audits, for example for infection prevention and control and for care plans.

● Some relatives spoke positively about the service. They told us they had regular contact and that they felt people received good care. One relative said, ''I can't fault the home.''

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 not always acted appropriately when things went wrong. Some relatives told us that they were not contacted by the service following incidents. One relative told us that they were not informed by the provider following an incident when a person was placed at harm (currently being investigated by the local authority safeguarding team). They only found out about this when the local authority contacted them. They also told us the provider had failed to tell them when the person was admitted to hospital, finding this out from the hospital staff.

● Other relatives told us they were happy with the level of information shared and they had been informed when people's health deteriorated or if something had gone wrong.

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

● There had been no registered manager at the service since January 2020. This was a breach of one of the

conditions of the provider's registration. Since this time there had been three different managers. Two of these managers applied to be registered and then withdrew their applications and left the service. The third manager did not apply to be registered with CQC. There were periods of time when no manager was in post. At the time of the inspection, the service was being managed by a manager (referred to as the acting manager in this report) registered to manage another care home. They were working at Fern Gardens Care Home three days a week. The provider supplied us with a proposed management structure which they felt would enable them to manage both services in the interim before a fulltime manager was in post.

● Staff commented to us that the frequent changes of manager had been disruptive with one staff stating, ''They promise but they don't [support us]; in the last two and a half years they keep saying they will give training but with the manager changing this has not happened.'' One relative also said, ''There have been so many different managers, I have lost count.'' They went on to say they had found one manager, ''rude and ignorant'' as they had not listened to their concerns.

● Some people using the service and relatives told us they did not know who was managing the service. Some explained they would speak with nurses if they had concerns.

● Most staff told us they felt the acting manager was supportive and they had seen them introduce improvements at the service.

● The acting manager was suitably experienced and a qualified nurse. They kept themselves updated with changes in legislation and good practice guidance. However, staff were not always as well informed. The staff did not always demonstrate a good awareness of good practice and there had been recent incidents where people fell, and staff had not followed procedures to move them safely; nor did they follow the local authority or provider's safeguarding procedures. The provider's training manager was working at the service four days a week to support staff to improve their skills, knowledge and competencies. They worked directly with the staff assessing them and providing training. The staff gave positive feedback about this experience and felt the training was well run and useful.

Working in partnership with others

● The provider had not always worked in partnership with others. A recent safeguarding investigation found the provider had failed to refer someone for additional help and support when needed. This, and a different previous safeguarding investigation, found the provider had not completed a detailed discharge summary when people moved out of the service, failing to inform the new care home about bruises, and a fall.

● The community matron visited the service several times a week and the provider worked with them and other visiting healthcare professionals to help assess people's needs and identify where improvements were needed. The community matron had raised a number of concerns directly with the service, and told us that until recently, these had not been acted on.

● The provider had allocated a senior manager to work with the safeguarding authority to review and implement protection plans following safeguarding meetings. This manager attended safeguarding meetings.

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

● The provider's systems for engaging with stakeholders had not always been followed. There had been a period of several months where no formal meetings for people, visitors or staff had taken place. Nearly all the relatives we spoke with expressed frustration about managing to speak with someone when they telephoned the service, with many commenting they could not get through or leave a message. Some relatives also explained they could not gain access to the service when they visited, with two people telling us they had waited over 40 minutes to get someone to answer the door.

● The acting manager was aware of these concerns and planned to address them, by providing better systems which would ensure a member of staff was available to respond to calls and support visits. They

had also started to supervise staff, sitting with individual staff to discuss their work.

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 10 HSCA RA Regulations 2014 Dignity and respect The registered person did not always ensure service users were treated with dignity and respect. Regulation 10

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered person did not always ensure complaints were investigated, or that necessary and proportionate action was taken in response to any failure identified by the complaint or investigation. Regulation 16