Macleod Pinsent Care Homes Ltd

Gracelands

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Graceland's is a residential care home providing personal care to up to 31 people. The service provides support to older people including people who live with Dementia, diabetes and Parkinson's disease. At the time of our inspection there were 19 people using the service. The care home is over two floors in one adapted building.

People's experience of using this service and what we found

People did not always receive person centred care that met their needs and preferences. Care records were not accurate or up to date and there was a risk that new or agency staff would not know how to meet people's needs safely or in accordance with their personal wishes and preferences.

Aspects of leadership and governance of the service were not effective in identifying service shortfalls. There was not an adequate process for assessing and monitoring the quality of the services provided and ensuring that records were accurate and complete.

People did not have any meaningful stimulation and occupation this included people living with dementia and people cared for in bed. Staffing levels were not always sufficient in meeting people's wellbeing needs in a person-centred and caring way and people did not feel there were enough staff to look after them effectively. There was a lack of engagement from staff and some people expressed boredom. People were not always treated in a compassionate way and our observations showed that people were not always treated with dignity and respect.

People told us the food was good. Staff told us they enjoyed working at the services. People had access to healthcare and visiting health professionals told us managers and staff were helpful.

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.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 28 January 2022). At our last inspection there was a breach of regulations. At this inspection we found the provider remained in breach of regulations.

At our last inspection we recommended the provider reviews the processes for recording and responding to incidents and accidents to ensure information is shared with relevant people in a timely way, the

environment is regularly reviewed and actions taken promptly to ensure it is safe, the provider seeks best practice on implementing the Mental Capacity Act guidance.

At this inspection we found the environment was safe. The service was applying the principles of the MCA appropriately and there were improved process for responding to incidents, accidents and sharing information.

Why we inspected
We received concerns in relation to the quality of food and people's diets, poor continence management, safety of the environment, medicines and staff skills and behaviour. As a result, we undertook a focused inspection to review the key questions of safe, effective, caring and well-led.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has deteriorated to inadequate based on the findings of this inspection. We have found evidence that the provider needs to make improvements. Please see the Safe, Effective, Caring 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.

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

Enforcement and Recommendations

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to providing safe care and treatment, treating people with dignity and respect and the management of the service 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 following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 always safe. Details are in our safe findings below.	**Requires Improvement**
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.	**Inadequate**
Is the service well-led? The service was not always well-led Details are in the well-led findings below.	**Inadequate**

Gracelands

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was undertaken by two inspectors on day one and one inspector on day two.

Service and service type
Gracelands is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Gracelands is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

At the time of our inspection there was a registered manager in post.

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. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with eight people who used the service and four relatives about their experience of the care provided. We spoke with nine members of staff including the registered manager, care workers, maintenance staff, chef and agency staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included eleven people's care records and multiple medication records. We looked at two 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.

Requires Improvement

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management; Staffing and recruitment; Preventing and controlling infection

At our last inspection we recommended environment is regularly reviewed and actions taken promptly to ensure it is safe. At this inspection improvements had been made and the environment was safe.

- The provider had taken action to improve the safety of the environment. Regular safety checks were undertaken by the facilities manager. Environmental risk assessments were in place to mitigate identified risks. Action had been taken to address fire safety concerns.
- People could not be assured of receiving safe care. Information contained in people's care records could not be relied upon as being accurate. For example, fluid balance records for people who required their hydration needs to be monitored showed discrepancies in what was recorded and what we had observed. Staff told us they made an estimate based on what they thought a person may have consumed during the day and recorded this as the actual fluid intake balance. Information recorded in people's care records was incorrect and misleading and placed people at risk of dehydration.
- The provider used a dependency tool to determine the numbers of staff on duty. People and their relatives consistently told us there were not enough staff and our observations confirmed this. Some people were highly dependent on staff for their basic care needs and some people were cared for in bed. We observed people waiting long periods of time for food and drink and for their continence and personal care needs to be met.
- People who were cared for in bed or chose to spend long periods of time in their rooms were not regularly checked. We observed a person who was receiving end of life care was not check for several hours and there was a failure to ensure their hydration needs were met. Relatives told us that no one answers the phone in the evenings or weekends and finding staff when they visit was difficult. A person said, "I suppose the staff are busy that's why you never see them".
- Prior to the inspection information was provided to CQC which suggested people did not always have access to call bells. Meeting minutes record the complaint was discussed during a team meeting on 13th June 2022. On day one of the inspection we observed a person who was cared for in bed did not have access to a call bell. Senior care staff told us this was an oversight. On day two of the inspection the person's care plan had been amended by the manager to reflect they were unable to use a call bell. The amended care plan recorded the need for hourly wellbeing checks, and we observed these were not taking place. Care staff told us they had not been made aware of the care plan change or the requirement to undertake hourly checks. This placed the person at risk from not receiving the help they wanted.

● On day one of the inspection the person in charge of the service was an agency worker and on both inspection days agency care staff were on duty alongside employed staff. We identified the call bell system had some incorrect names against bedroom numbers and some people's bedroom doors did not have names. There was a risk that unfamiliar staff responding to a call bell could provide the wrong support because the person who was in the bedroom was not the person who the call bell had identified required support.
● We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed. This is because staff were not wearing PPE inline with current government guidance.
● We were not assured that the provider was using PPE effectively and safely. On both inspection days on our arrival staff were not wearing face coverings appropriately. On day one the door was opened by an agency worker who had their facecovering under their chin. A second care worker was also observed wearing their face covering this way. On day two of the inspection we entered the lounge with a care worker. There were nine people in the lounge and four staff receiving handover. The care worker signalled to staff to pull up their face coverings up. We observed that all four staff participating in the handover were not wearing face coverings in line with current government guidance. We addressed this with the senior staff on duty at the time.

The provider had failed to ensure care and treatment was provided in a safe way. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Safe recruitment processes protected people from the recruitment of unsuitable staff. Appropriate recruitment checks were undertaken to ensure staff were safe to work with people. This included undertaking appropriate checks with the Disclosure and Baring Service (DBS) and obtaining references. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● Prior to the inspection we received concerns about people's mobility. At inspection processes were in place to mitigate the risk of people falling and records showed these had been effective in reducing falls. We observed people using equipment to reduce their risk of falling such as sensor mats and walking aids. The environment was clear of obstacles and we observed people mobilising freely around the care home. People told us they felt safe with the measures in place to mitigate their risk of falling. People who were cared for in bed or who had reduced mobility used equipment such as air flow mattresses and pressure reducing cushions to reduce pressure areas forming.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider's infection prevention and control policy was up to date.

We have also signposted the provider to resources to develop their approach.

Using medicines safely
● Medicines were not always managed safety.
● People did not always have access to their prescribed medicines. Over a 21 day period five people could not be administered their medicines because these were not available within the care home. A combined

total of 117 doses of medicines were unavailable to be administered. This included medicines to treat constipation, pain relief, medicines to thin the blood and to treat iron deficiency. The manager told us they had been experiencing delays with the GP sending prescriptions to the pharmacy and pharmacy stock. Where prescribed medicines were not available this information was not reflected within people's care notes.

● For example, one person missed 31 consecutive doses of medicine to treat constipation because their prescribed medicines were not available. There was nothing in their care records to advise staff of this and consideration had not been given to increasing fibre in the persons diet. The person's bowel movements were not being monitored because electronic records were not kept, and paper records could not be found.

● Another person missed three doses of medicines because they were out of stock however their care notes recorded all medicine had been given. There was no evidence of a negative impact for the people however were not assured as to the accuracy of the information that was being recorded. Accurate records were not maintained to monitor people's wellbeing when prescribed medicine were not available. This exposed people to the risk of harm.

● Medicine care plans were not always in place and failed to provide guidance to staff about people's medicines. There was an absence of information to guide staff about how people preferred to receive their medicines and how staff could support people to maintain their independence. This meant people could not be assured of receiving their medicines safely and in line with their personal preferences and the prescriber's instructions.

We spoke to the registered manager who told us they had improved processes for ordering medicines to mitigate the risk of them being unavailable. They provided verbal assurances that staff administering medicines would ensure people's care records reflected that medicines had not been administered and monitoring would be implemented.

The provider had failed to ensure systems and processes were established and operated for the safe management of medicines. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff completed training to administer medicines and their competency was checked. Medicines were stored and administered safely and in line with National Institute of Health and Care Excellence (NICE) guidance. Accurate records were maintained for controlled medicines. The Misuse of Drugs Act 1971 places controls on certain medicines. These are known as 'controlled medicines'. Protocols were in place for people who required medicines to be administered 'as and when required' (PRN). People told us they received appropriate support with their medicines.

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

At our last inspection we recommended the manager reviews the processes for recording and responding to incidents and accidents to ensure information is shared with relevant people in a timely way. At this inspection the manager had made improvements.

● Processes were in place to ensure concerns about people's safety were reported to the relevant people and organisations. Staff had access to the local authority safeguarding protocol and information was available on how to report a concern. The manager reviewed all accidents and incidents to look for trends and ensure relevant professionals were involved.

● Staff had received safeguarding training and understood their role in safeguarding people. Training was designed to aid staff understanding of signs of abuse and why it was important staff acted if they recognised

any concerns. Staff we spoke with were knowledgeable about the different types of abuse and how to raise a concern. One staff member said, "I would report any signs of abuse to the manager straight away."

● People and their relatives felt that staff protected them from the risk of harm. Relatives told us they were contacted if their loved one had an accident or sustained an injury. Body charts were in place to record any bruises and skin tears and these were monitored for trends. A relative told us they had seen staff support their loved one to transfer into a chair. They told us staff had been gentle and they had no concerns

Learning lessons when things go wrong

● Not all lessons had been consistently learned and embedded in to practice. Previous inspections had raised concerns around infection control processes and the lack of robust processes for secure and accurate record keeping. This inspection found continued concerns in these areas.

● Other lessons had been learned and improvements seen. Accident and incident records were reviewed by the registered manager and there was an opportunity to learn from these and use this as a tool to drive improvement. At the last two inspections we raised concerns about the environment. Some improvements had been made in this area and work was ongoing.

Visiting in care homes

● Relatives told us they were able to visit the service. They were able to meet their loved ones in their bedrooms or in a specifically designated visitor room. Visitors to the service told us they wore masks and had to show evidence of a negative of a negative lateral flow devise (LFD) test. Medical professionals were visiting the service during the inspection and wore PPE.

Requires Improvement

Is the service effective?

Our findings

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

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

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

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

At the last inspection we recommend the provider seeks best practice on implementing the Mental Capacity Act guidance. At this inspection improvements had been made.

● MCA assessments and best interests' decisions were in place where required. DoLS authorisations had been applied for and approved for the appropriate people; the registered manager checked DoLS authorisations to ensure they remained valid. Where people's DoLS had been authorised with conditions these were monitored to ensure the conditions were met.
● Staff had undertaken MCA training and knew how to apply the MCA framework when supporting people with decisions about their care. Staff were aware of people living at the service who had a DoLS in place. For example, a staff member told us about a medicine review for a person who had an authorised DoLS condition regarding medicines. This meant staff could recognised if a person's liberty was being deprived without lawful consent.

Supporting people to eat and drink enough to maintain a balanced diet
● People who were dependant on staff for their hydration needs were at risk from dehydration and urinary tract infections (UTI). Process were not in place for monitoring people's fluid intake. The NHS recommends adults to have between 6-8 cups of fluid a day. This equates to 1200-1600mls per day. This is known as the recommended daily allowance (RDA). Processes were not in place to identify or act promptly when people failed to achieve their RDA. One relative told us they had visited their relative in their room for several hours recently and no one had checked to see if they were still there or if their loved one wanted a drink.
● People were not always provided with appropriate mealtime support. We observed minimal interaction

from staff at mealtimes and some people did not always receive the level of support identified within their care plans. For example, we observed a person who was a diabetic and was cared for in bed. Their care plan said they needed encouragement to eat and drink. At 12.40 the person was observed to be in bed asleep and there was a plate of warm food on their bedside table. At 4pm the person was still asleep, and their meal was cold and untouched. We observed during this time staff had not made checks on the person. We made staff and a visiting health professional aware of our concerns. They were able to encourage the person to wake up and take some fluids.

● Prior to the inspection information was given to CQC that suggested people were given food products that were that were out of date. At inspection we identified some bakery products that were out of date. There was no evidence these had been given to people to eat. On day one of the inspection we observed a person's meal remained on the unheated food trolley for 35 minutes before it was served to them This meant the food prepared was not always kept hot which may have impaired people's enjoyment of the meal.

● Care plans included information about people's dietary needs and choices. We observed people being offered alternatives to the main meal and extra puddings on request. Meals were nutritious and people told us the food was good. People's weights were regularly monitored and recorded. Where there had been unaccounted weight loss suitable actions had been taken to seek additional support and guidance. For example, some people had fortified meals to increase their calorific intake and mitigate their risk of weight loss.

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

● People's needs were assessed before they started to receive support from the service, to ensure their needs could be met. Some people's care plans did not reflect information provided from hospital discharge or assessment. For example, one person health conditions were not reflected on their care plan. This included the failure to record the person had Chronic Obstructive airway Disease (COPD) and the support they required to manage this.

● On day one of the inspection the registered manager was updating people's electronic care plans whilst working from home. This meant people and those close to them were not involved in the updating and reviewing of their care plans.

● The information gathered included people's preferences, backgrounds and personal histories. This ensured people's diverse needs were considered and promoted within their care. For example, one person had recently celebrated their birthday with food and music from the country of their birth.

● A range of assessment tools were used to ensure people received care and support appropriate to their needs. The Waterlow tool was used to assess the risk for the development of pressure sores and Malnutrition Screening (MUST). People had personal evacuation plans (PEEPS) in place to aid safe evacuation in the event of an emergency. Falls assessments were undertaken and these had been effective in reducing the number of falls.

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

● The service was undergoing refurbishment to update the environment and facilities. For people living with dementia, the environment did not enhance orientation or communication. We fed this back to the registered manager who said they would share our observations with the provider. Adaptations had been made to meet the needs of people using wheelchairs and walking aids.

● People's preferences were used to enhance their bedrooms which were personalised and contained personal effects such as pictures, photos, equipment and items to support their hobbies and interests.

Staff support: induction, training, skills and experience

● Staff completed training that was relevant for their roles. This included training in areas such as,

safeguarding, first aid, moving and handling and food hygiene. Staff had opportunities to learn skills to enable them to support people's assessed needs for example some staff had undertaken catheter care training. Records showed that staff were competent to provide care safely and effectively to people.

● Staff new to care undertook the Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.

● The service was reliant on agency staff to ensure safe staffing levels. Agency profiles were in place which demonstrated that agency staff had the required training and induction before working at the service.

● Staff received supervision and support from the management team. The management were also supported by an area manager who visited the home each month.

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

● Care records showed that people had access to routine and specialist health care appointments. Records were kept about health appointments people had attended and staff ensured that guidance provided by health care professionals was implemented. We spoke with the manager about how they could improve the way they documented advice from medical professionals obtained over the telephone and ensured it was reflected in people's care records.

● Staff liaised effectively with other organisations and teams and people received support from specialist health care professionals. Records showed that people had regular access to health care professionals, GPs and specialist nurses. During the inspection health care professionals visited the service on both days to provide support to people and guidance to staff. We observed communication between a healthcare professional and staff. This was professional and informative and demonstrated how people's healthcare needs were reviewed to ensure they received appropriate medical treatment in a timely way.

● People's oral health care needs were met.

Inadequate

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 our last inspection we rated this key question good. At this inspection the rating has changed to inadequate.This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

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

- People were not always treated with dignity and respect.
- On day two we observed the morning staff handover in the lounge. Staff were openly discussing a person who had passed away during the night. There were nine people also in the lounge including the spouse of the person who had passed away. They were also a resident at Gracelands. Consideration was not given to the confidentiality of the information being discussed during the handover. This included a lack of consideration as to the impact on the person hearing their spouse's death being discussed so openly. Comments from staff included "Well it was his time", and "[name] said this morning she had seen a vision of him in the night, I believe in all that stuff".
- After the handover the we observed the person who had been widowed overnight. They remained in the lounge with colouring pens and book for the remainder of the day. Staff passing through the lounge offered no additional comfort or support and none asked after her wellbeing. Staff asked another resident to keep an eye on the person. They told us "I don't get paid to do that, it's a staff job". We also observed a staff member entering the lounge and asking the person in a very loud voice if their husband was for cremation or burial. The person replied burial and the staff member said "Great" and left the room. The registered manager observed this and arranged for some comfort to be provided to the person.
- Not everyone had a positive mealtimes experience as it was not person centred. We observed staff feeding people whilst standing in front of them and talking to other staff. One staff member was watching television and was not aware of the person leaning forward with their mouth open in attempt to reach the spoonful of food the staff member was holding. People being supported by staff to eat were regularly interrupted by the need for staff to support another person. Comments from staff about people at mealtime included "This one's done brilliantly". And "Feed this to [name], I can't I hate the meat, I will feed [name]".
- People were given drinks and a sweet treat in the afternoon without being asked what drink they would like or what the sweet treat was. One person asked, "Is it cake?" staff replied, "I don't know" and continued to walk through the lounge. We observed a person coming into the lounge at 11.35 and being offered a cold cup of tea that had been poured at 11am. We also observed staff cleaning the dining table with a chemical spray whilst people were still eating their meals. At lunch time, people who ate in their bedrooms still had dirty crockery and uneaten food in their bedroom at 4pm. This did not provide people with a dignified and person-centred approach to mealtimes.
- Staff communication with people when they were not supporting people with direct care was poor. We observed people in the lounge being left for long periods of time whilst staff sat at a table together talking or

stood watching the television. This happened on several occasions on both inspection days.
● People told us they did not always receive compassionate care and support. We identified that one person had the wrong name on her bedroom door. This person had been in the room for a week and staff had not changed the name. We observed staff supporting a person to walk from their bedroom to the lounge. The staff member was not very compassionate in their approach to the person. Another member of staff informed them of our presence and the staff's attitude changed to one of support and encouragement. Feedback from people about the care they received was negative. One person described the staff as "Terrible" and "Uncaring". Another said, "Too many new faces so they never seem to know what they are doing".
● We received mixed feedback from families about the care their loved ones received. One described the staff as gentle and polite when they support their loved one. Feedback from others centred mainly on the changes of staff and the negative impact this had on people who had memory problems. Relatives also told us that sometimes their loved ones were dressed in other people's clothes, there was a lack of activities and stimulation and communication was very poor. Some relatives told us when they walked through the care home, they felt a loss of dignity for people who were sitting in the lounge with food around their mouths and looking "Dishevelled". We observed people wiping their mouths on their sleeves at lunch time as there were no napkins provided. One relative said, "It breaks my heart to see people looking like that".

There was a failure to treat people with dignity and respect. This is a breach of Regulation 10 (of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Dignity and respect)

● We observed some positive interactions from agency staff and from staff who were not employed to provide direct care. For example, we observed maintenance staff having positive interactions with people and knocking on bedroom doors before entering.
● People told us they enjoyed seeing the registered managers dog who was a regular at the care home. People describe the dog as "Gorgeous", one person said, "I really look forward to seeing him". Another said" I love to stroke it, it's so calming". The registered manager and ancillary staff regularly bought their dogs into work with them. Risk assessments were in place for this.
● Subsequent to the inspection the registered manager told the inspector that during the inspection a person had told the registered manager that they "loved living here'.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At our last inspection systems were either not in place or robust enough to ensure records were maintained securely and accurately. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● There was a lack of effective oversight and monitoring of the service. Strategic governance and quality monitoring processes had failed to ensure compliance with regulations. There was a continued failure to keep accurate and contemporaneous records and to ensure effective management of the service. This is the fourth consecutive inspection where this key question has been rated requires improvement.
● Quality monitoring systems had failed to identify that care plans did not provide accurate and up to date information. We found examples across multiple people's care plans where information was missing or not up to date.
● For example, during the inspection the registered manager had updated a person's care plan. They had failed to identify the care plan said the person's blood sugars were monitored weekly when this was not the case. The registered manager said the care plan was inaccurate and this had been an oversight by them. There had been a failure to identify gaps in some people's daily monitoring records and some records were missing. This meant people were at risk of not receiving the correct support as the provider did not have a robust system to ensure people were receiving the care they needed and that records were accurate.
● Systems and processes failed to identify and assess risks to the health safety and welfare of people. For example, there had been a failure to identify people were at risk of dehydration. This included during the government heatwave warning issued between 17-19 June 2022. Records within the service failed to demonstrate this information had been passed onto staff or that people's fluid intake had been increased. This risk was increased further by the failure to identify fluid monitoring records were inaccurate. The lack of management oversight of documents meant that the provider had failed to identify support was not always being given in line with people's support plan requirements.
● There was a failure to identify people were not treated with dignity and respect. Operational oversight of the day to day management of the service had failed to identify a culture which did not always deliver care

and support in a person centred or dignified way. The manager did not have a strategic approach to changing the culture of the service. They told us it was their hope that new staff would bring positivity and improved practice.

● There had been a failure to consider confidentiality of personal information when holding staff handovers in a communal area. This meant people's personal information was being shared openly in front of others. The provider did not always maintain people's privacy in respect of unauthorised access to confidential data by ensuring that that personal information was stored securely. People's daily monitoring records were kept in the lounge and were freely accessible. This meant people could not be assured that their personal and sensitive data was being protected and handled in line with General Data Protection Regulations (GDPR).

The provider had failed to take the necessary steps to improve. There was a continued failure to ensure adequate systems to assess, monitor and improve the quality and safety of services provided, including risks to the health, safety and welfare of people and others. Accurate and contemporaneous records were not always maintained regarding people's care. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Visitors to the service told us that when they have had cause to raise things with the registered manager they were listened to. We received mixed responses as to whether they received positive outcomes. People and relatives told us they did not always experience effective communication. One relative told us it was difficult to know whether the breakdown in communication was between the registered manager and staff or as a result of staff actions. People told us staff seemed too busy to listen or remember things.

● Relatives told us the manager kept them up to date with matters arising with their loved one and were always contacted immediately when there was a concern.

● Services that provide health and social care to people are required to inform CQC of important events that happen in the service in line with regulatory requirements. The provider had informed CQC of significant events in timely way. This meant we could check that appropriate action had been taken.

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

● Satisfaction surveys had recently been sent to relatives and professionals. There was a poor response to these with only one being returned. Newsletters were sent to families to keep them up to date with news and events.

● During the inspection process we received feedback from people, visitors and staff. Staff had mixed experiences of supervision. Some staff received supervision more frequently than others. Team meetings took place and staff told us that they had the opportunity to raise concerns and ideas. Staff enjoyed working at the service and spoke highly of the registered manager. One told us, "Things have improved, it's much better than it used to be, the manager is very approachable. Another said, "Changes have been made for the best".

● The service worked in partnership with other agencies. These included healthcare services as well as local community resources. Staff were aware of the importance of working with other agencies and sought their input and advice. A visiting professional told us information requested was produced and staff always made themselves available to discuss any issues. Another told us they found the team helpful.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure care and treatment was provided in a safe way.

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	Regulation 10 HSCA RA Regulations 2014 Dignity and respect There was a failure to treat people with dignity and respect.

The enforcement action we took:

Warning Notice was issued . The provider was required to become compliant in this regulation by 17 October 2022

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure systems and processes were established and operated for the safe management of medicines. The provider had failed to take the necessary steps to improve. There was a continued failure to ensure adequate systems to assess, monitor and improve the quality and safety of services provided, including risks to the health, safety and welfare of people and others. Accurate and contemporaneous records were not always maintained regarding people's care.

The enforcement action we took:

Warning Notice was issued . The provider was required to become compliant in this regulation by 17 October 2022