Baystone Limited

Cranford Residential Home

Inspection report

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Devon
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Cranford Residential Home a residential care home providing accommodation and personal care to up to 26 people. The service provides support to older people, including people who are living with dementia. At the time of our inspection there were 20 people living at the service; one of whom was on a short stay arrangement.

Accommodation is provided over the ground floor and first floor. There are two flights of stairs in the home (one is for staff use only) and a passenger lift, which enabled people to access the first floor. The majority of bedrooms had ensuite facilities. The lounge and the dining room are on the ground floor. At the side of the home is a large open mature garden.

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

During the inspection a number of concerns were identified and shared with the provider while we were on site. The provider took quick action to engage a consultant care company to manage the home and oversee the governance. From 12 February 2023, an interim manager from the consultant care company was based at the home with additional support from an operations manager. The provider also engaged a legal team to ensure they took the appropriate action to investigate the conduct of one staff member. The provider took the matter seriously and has worked alongside CQC and other agencies to address the issues.

During the inspection, we saw due to poor risk assessment decisions, risks to people's safety were not reduced. There was poor oversight of people's oral health care. Risks to people's health were not always effectively monitored. A lack of regular environmental checks and fire training potentially put people at risk of harm.

Staff deployment did not consistently meet people's care and social needs. When shifts ran below planned staffing numbers, staff said people's personal care and entertainment were often impacted. Call bell records showed staff did their best to respond in a timely way but there were occasions when wait times were lengthy.

Care staff undertook training, such as moving and handling. However, not everyone had completed a course on dementia awareness despite the care needs of many people living at the home. Some staff told us they had received training in safeguarding and knew their responsibilities. However at the time of the inspection, not all staff had completed this course. This had not been addressed by the registered manager or the nominated individual.

The culture and the way the home was managed left staff feeling unsupported and overwhelmed at times. Staff were working additional hours to cover sickness, vacancies and absences; they were demoralised and saddened by the negative changes in the atmosphere and the management of the home.

Poor governance arrangements and oversight meant risks had not been identified or addressed. This included risks related to malnutrition, dehydration, lack of mental and emotional stimulation, poor personal care, staff training and environmental risks. The provider had recruited an experienced manager and nominated individual; we saw evidence of a thorough recruitment process. Despite regular visits by the nominated individual, ineffective action was taken to address concerns being raised.

Despite these issues, people living at the home did not raise concerns regarding their safety or well-being. Visitors said their relative was safe at the home; they had confidence in the staff team. For a few people in the lounge we saw how they enjoyed a quiz and an exercise class run by an agency member of staff, who obviously knew them well and laughed and joked with them. We could see how people who been sleepy and quiet became engaged with others by the social interaction.

Despite staff administering medicines being constantly interrupted with queries or phone calls, people told us they got their medicines on time. The storage and administration of people's medicines was safe. The risk of the spread of infection was well managed as staff were aware of their responsibilities. For example, people commented on the cleanliness of the home and the running of the laundry. People said their clothes were well cared for and did not get lost.

People living and visiting the home were complimentary about the attitude of staff. For example, "It's alright, I've settled in, the staff are all very nice", "There are better places, but the staff are kind", and "My dad is happy here, he's content." A visiting health professional told us staff were "very caring and compassionate." Despite the staff often being extremely busy, we saw staff were kind and thoughtful towards people living at the home. When they spoke about people, they were respectful, and it was obvious from their conversations they knew people well.

People's individual tastes and preferences were catered for. For example, one person said they liked porridge and a bowl of crisps for their breakfast which we saw being served to them. Other people said they enjoyed the option of a full English breakfast. Relatives praised the quality of the food and the work of the chef. They said, "He loves the food… he has choices and says it is excellent" and "The food and the chef are brilliant. They are very amenable and know what mum likes."

Following our feedback during the inspection, the provider took prompt action to contract with a care consultancy company to oversee the management of the home. They adapted their action plan as more information came to light which showed they were responsive and took the concerns seriously. They were upset and shocked. Since the inspection, their actions have placed the well-being and safety of people living and working at the home at the heart of their plan to improve the service. They have provided CQC and the local authority with an on-going action plan for the consultants role and a service improvement plan for the home. They have been open and worked alongside external agencies to ensure people are safe and the staff group are well led.

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

Rating at last inspection
The last rating for this service was good (published 18 August 2018).

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

Why we inspected

Staff and people who had worked at the home contacted CQC with concerns regarding the management of the service, how staff were deployed, staff turnover, and the impact on the quality of care provided. Two relatives also contacted us with concerns linked to falls management, communication and dignity concerns. A decision was made for us to inspect and examine those risks.

Enforcement and Recommendations
We have identified breaches in relation to safe care and treatment, staffing and good governance.
Please see the action we have told the provider to take at the end of this report.

Follow up
We met with the provider on 14 February 2023 to discuss our regulatory response and review their action plan. We participated in whole service safeguarding meetings to monitor the management of the service and the well-being and safety of people living at Cranford Residential Home. We will continue to work alongside the provider and 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 safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Cranford Residential Home

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was conducted by two inspectors, an assistant inspector, and two Experts by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Cranford Residential Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Cranford Residential Home 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 provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post. However, they have since resigned. The nominated individual has also resigned. An interim management consultancy company currently oversees the running of the service until a new manager is appointed. They are working closely with the provider and

have taken on the nominated individual role on a long-term basis. The provider also plans to engage the work of an external auditing company to review the work of the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

Notice of inspection
This inspection was unannounced on 7 and 9 February 2023. On the 14 February 2023, we gave feedback to the provider, registered manager, nominated individual and the consultant care company.

What we did before the inspection
We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make.

We reviewed information we had received about the service since the service was registered. We used information gathered as part of our monitoring activity that took place on 6 May 2022 to help plan the inspection and inform our judgements.

We spoke with health and social care professionals who are either in contact with the service or regularly visit the service.

We used all this information to plan our inspection.

During the inspection
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 may not be able comment directly on their care.

An Expert by Experience spoke with 8 people living at the home and 2 relatives on 7 February 2023, and 10 relatives on 10 February 2023, to gain their feedback on the service. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We spoke with 11 staff and gave them an opportunity to respond to us by e-mail. We also spoke with the registered manager, the nominated individual, the care consultants and the provider. We reviewed a range of records. This included 6 people's care records and people's medication records. We looked at 3 staff files in relation to recruitment and looked at records relating to staff supervision and training. We reviewed a variety of records relating to the management of the service, including minutes from staff meetings, handover notes, audits and rotas. We completed a tour of the building.

On the first and second day of inspection, we gave verbal feedback during the day to the registered manager. We also gave feedback to the nominated individual and provider during the second and third day, as well as sending an e-mail detailing our most significant concerns and requesting evidence of action being taken to address them.

The inspection concluded on 14 February 2023 when verbal feedback was provided to the registered manager, the nominated individual, the provider and the management consultants.

Inadequate

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 good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

● Due to poor risk assessment decisions, risks to people's safety were not reduced. For example, one person living with dementia was at increased risk of harm due to the decision to retain bedrails despite an incident which indicated bedrails were not safe for this person to use. Advice was not routinely sought from external health professionals when assessing risks, which meant best practice was not adopted to mitigate them. We found other examples of poor risk assessment decisions.

● There was poor oversight of people's oral health care. Some people had been assessed as needing or had requested support with cleaning their teeth or dentures. One person's care plan said, 'I would like to have my teeth brushed twice daily. I need assistance to maintain my oral hygiene.' Their records showed they only received support with cleaning their teeth on 2 occasions in 11 days. These 2 occasions took place following our inspection, when we highlighted the concern. We found other examples of poor risk assessment decisions.

● People were put at risk of pain and infection due to a lack of guidance regarding catheter care. A whistle-blower contacted CQC as they were concerned one person was experiencing pain due to poor catheter care. Records showed their catheter care was not being managed appropriately. Following feedback from CQC to health and social care professionals during the inspection, the community nurse team reviewed their care and gave guidance to the staff team.

● Some people's personal hygiene was neglected. Some people had been assessed as needing help with washing and changing their clothes. Self-neglect had been one of the reasons one person had moved to the home. At a health appointment, their relative had been distressed by their appearance as the person's clothes were dirty, undermining the person's dignity. This was despite the aim of their care plan 'to remain clean, dry, smart and comfortable each day'. Records showed there were multiple days when their parent had not received the help they needed.

● Risks to people's health were not effectively monitored. People's weights and risk of malnutrition/dehydration were ineffectively reviewed, which meant action had not always been taken to reduce or identify an increased risk. For example, if they experienced unplanned weight loss, or were at risk of dehydration, and required increased monitoring of their fluid intake.

● A lack of regular environmental checks and fire training potentially put people at risk of harm. For example, window restrictions were not routinely checked to ensure they were in place and effective. The home's fire risk assessment had not been updated and fire drills with staff were not carried out frequently.

Risks were not well assessed, monitored or managed and people were at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Despite the above, people living at the home did not raise concerns regarding their safety or well-being.

Visitors said their relative was safe at the home and they had confidence in the staff team.
● Due to the level of concern, CQC contacted the providers during the inspection giving verbal and written feedback. The providers responded quickly to the above concerns as soon as they were made aware of them. This included promptly putting in place care consultants to manage and oversee the running of the home. They immediately reviewed people's care and took action to keep them safe. They also addressed the environmental risks, for example checking, and where necessary, replacing window restrictors, arranging fire drills and organising for the fire risk assessment to be updated.
● Records relating to one person, who was falling more frequently, showed there were risk assessments and a care plan in place linked to their mobility and risk of falling. We saw health professionals had been contacted for advice, staff were monitoring the person's health and a hospital appointment was due for further investigation into the cause of their falls.

Learning lessons when things go wrong
● Lessons were not learnt. For example, the registered manager had two dogs which they brought into the home. They had injured three people. Previously, the dogs had also damaged furniture and defecated and urinated in the home.

Known risks were poorly managed and put people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Staff deployment did not consistently meet people's care and social needs. When shifts ran below planned staffing numbers, staff said people's personal care and entertainment were often impacted. For example, showers were offered less frequently, and social activities were cancelled. This was confirmed by records and discussions with people living at the home. A staff member said, "I do feel it does have an impact on the residents when we are short of staff and I personally feel we don't get much support from the manager. They have to wait longer, and they do not get as much attention as they need. We do have some quite challenging residents, so they get a lot of our time, which of course they need, but it is difficult when there is not enough staff."
● Agency staff were used on most shifts but had not been block booked to help ensure continuity and consistent cover. A staff member said being short staffed had, "A big impact on residents, of course. We cannot give showers every day like you would want to, but we cannot do it when we are short, and so cannot give the quality of care to the residents." Some agency staff had refused to return because of the chaotic atmosphere at the home. The good will of the staff team meant they would often work extra hours or had changed their duties to cover sickness, absence or agency staff not arriving for their shift. The staff team said they were 'firefighting', and many were exhausted and demoralised. After the inspection, the consultants shared how they had found no recruitment process for new staff had been in place, despite the registered manager knowing the staffing issues.
● Call bell records showed staff did their best to respond in a timely way but there were occasions when wait times were lengthy. This was confirmed by people living at the home, who for example, needed assistance to use the toilet. The registered manager had not investigated the cause of the delays, for example, a wait of 45 minutes. A relative said, "Mum feels there are skeleton staff at the weekends." A person living at the home said, "There are good days and bad days, I am dependant on the carers…I have often wondered if they're ever going to show."
● On the second day of our inspection, a permanent member of staff had rung in sick and an agency staff member had not turned up. The registered manager had left the building. The atmosphere was hectic, and breakfast had been delayed. Staff confirmed one person had been sat in the dining room for 45 minutes and was still waiting for a hot drink and their breakfast. Community nurses had arrived to administer insulin for 2

people, who had not yet been served their breakfast, which caused delays and was not best practice.
● Staff told us the registered manager left the building when they were supposed to be on shift and did not routinely inform staff. During our inspection, we saw this happen. At the end of the second day of inspection, the registered manager told us they had to leave but they had not ensured staffing levels were safe. This was despite knowing an agency member of staff had walked out earlier. A staff member was left with the task of trying to find cover. We did not leave the building until this staff member arrived. We contacted the providers to voice our concern, and they took immediate steps to arrange an interim manager to oversee the home. Some people told us they loved to go into the garden for a walk, but this was frequently cancelled due to a staff member not being free to walk with them. Records confirmed this. The registered manager had asked staff to complete activities on top of their care shift. Activities were often cancelled or delayed as staff struggled to complete care tasks. A staff member said, "… we try our best to do some activities but it is really difficult when you do not have enough staff to cover … normally do something like today, we did a little quiz or we'll try and paint nails or something little..." Records showed there was little social stimulation for people, particularly those cared for in bed or who chose to stay in their room.

Staff deployment had not been managed appropriately to ensure there were sufficient numbers to keep people safe. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager had delegated recruitment administration to another staff member. The staff member had ensured there were appropriate records in place, such as a full application form, references, checks on the applicants suitability to work, and identity documents.
● During the inspection, the provider appointed an interim manager, who addressed the delays in people having their breakfast. They also worked with the community nurse team regarding the routines of people requiring insulin. Block bookings for agency staff were introduced, and adverts for jobs were put in place.
● We saw how a few people in the lounge enjoyed a quiz and an exercise class run by an agency member of staff, who obviously knew them well and laughed and joked with them. We could see how people who been sleepy and quiet became engaged with others by the social interaction.

Systems and processes to safeguard people from the risk of abuse
● Staff told us they had received training in safeguarding and knew their responsibilities. However, not all staff had completed this course. This had not been addressed by the registered manager or the nominated individual.
● During the inspection, CQC made safeguarding alerts for individuals and participated in a whole service safeguarding process with the local authority. Consequently, health and social care professionals completed reviews with individuals to ensure their health and social care needs were being met. Where necessary, referrals were made for individuals, for example specialist referrals, for health conditions.
● The providers worked in partnership with the safeguarding process showing they were committed to addressing the concerns raised by whistle-blowers and the CQC inspection. They kept professionals and the staff team up to date with actions taken to address concerns regarding people's safety and well-being.
● During the inspection, when issues were highlighted to the provider regarding the conduct of some staff members, they took appropriate action to address the concerns.

People's medicines were managed safely.
● Despite staff administering medicines being constantly interrupted with queries or phone calls, people told us they got their medicines on time. The storage and administration of people's medicines was safe.
● The staff who administered medicines had undertaken training in the safe handling of medicines. We saw they administered medicines in a safe way and kept records appropriately. Where covert medicines were

used, appropriate health professionals had been consulted.
● However, neither the registered manager nor the nominated individual had identified the audits for the medicines fridge showed the wrong fridge temperature was being used as a baseline. A full sharps bin was also stored in the registered manager's accessible office which put people at risk of harm. These issues were both addressed during the inspection to keep people safe.
● Accessible personal medicines were also stored in the office, which the registered manager removed when we highlighted it was unsafe practice.

Preventing and controlling infection
● The risk of the spread of infection was well managed as staff were aware of their responsibilities. For example, people commented on the cleanliness of the home and the running of the laundry. People said their clothes were well cared for and did not get lost.
● Staff were clear about infection control measures, particularly after working through a Covid 19 outbreak. Relatives praised the staff team for the measures they took to keep people safe during this period. We saw good practice during our inspection.
We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises.

Visiting in care homes
● People were supported to see visitors in line with current UK Government guidance. At the time of our inspection there were no restrictions on visiting.

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 good. At this inspection the rating has changed to requires improvement. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- People were at risk of harm because staff had not received appropriate support, training and professional development. Staff said under the previous manager they had been supported to develop their professional qualifications and roles, such as 'train the trainer' in moving and handling. Staff said renewal training had not been supported by the current registered manager. Training had been limited to on-line courses, partly because of the impact of Covid 19. There was conflicting information over whether staff were paid for training. Staff said they were not paid and had to complete training in their own time. This was difficult for staff already working over their agreed hours.
- Records showed some staff did not receive regular supervision. The registered manager had delegated some supervisions to care co-ordinators on top of other additional duties. This meant the care co-ordinators sometimes struggled to fulfil this supervisory role when they were also working on the floor as part of the care team. For example, during the inspection, a care co-ordinator's shift was recorded as an 'admin day'. She had booked a supervision with another staff member but had to cancel it as she was working on the floor providing hands on care.
- According to care records, staff files, and our discussions with staff, some people living at the home had a diagnosis of dementia. Not all staff had received training in this area of care. This included one staff member who had worked at the home for five months, but never worked in care before. We requested the staff training matrix from the former registered manager, but this was not sent to us.
- The registered manager had delegated sourcing practical moving and handling training to a care co-ordinator. The care co-ordinator had liaised with other care homes to arrange training for staff, who were now on a waiting list. In the meantime, a new night staff member was supported by a trained staff member; they both moved people together. The new staff member was involved in moving people without practical training based on current best practice. They had never worked in care before.
- The registered manager told us they managed the rotas. They acknowledged they might need to review the weekend cover as an inexperienced senior staff member was struggling to manage shifts consisting of agency staff, including some who had never worked at the home before. In contrast, a more experienced member of staff was assigned to manage a team of permanent staff on alternate weekends. This showed a lack of foresight or understanding of their team's skills and experience.

There was a failure to ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed at the service. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● In response to our feedback during the inspection the provider arranged for the interim manager to access appropriate training for staff. They also began checking staff competencies to ensure their practice was safe. The provider confirmed staff were paid for completing mandatory training.
● After the inspection, a staff member who had been carrying out many management responsibilities was promoted to deputy manager and took over the staff rota to ensure there was a good skill mix of staff on each shift.
● People living and visiting the home were complimentary about the attitude of staff. For example, "It's alright, I've settled in, the staff are all very nice", "There are better places, but the staff are kind", and "My dad is happy here, he's content." A visiting health professional told us staff were "very caring and compassionate." Despite the staff often being extremely busy, we saw staff were kind and thoughtful towards people living at the home. When they spoke about people, they were respectful, and it was obvious from their conversations they knew people well.
● All staff, regardless of their role or department, clearly felt a collective responsibility towards the people living at the home and were worried the home was no longer providing the quality of care they wished to provide. They said they were very aware the local reputation was slipping, and this made them very sad as they had been proud to work at the home.

Supporting people to eat and drink enough to maintain a balanced diet
● People's individual tastes and preferences were catered for. For example, one person said they liked porridge and a bowl of crisps for their breakfast which we saw being served to them. Other people said they enjoyed the option of a full English breakfast. Relatives praised the quality of the food and the work of the chef. They said, "He loves the food… he has choices and says it is excellent" and "The food and the chef are brilliant. They are very amenable and know what mum likes."
● Catering staff said they would like more involvement with the care staff and registered manager to ensure they were made aware of when people moved to the home or if their health needs had changed, which might impact on their diet or food preparation. This was addressed by the interim manager.
● One person needed their food prepared in a way to keep them safe. Catering staff followed the advice given by the speech and language team.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● The advice of external health professionals advice was not routinely requested, for example in relation to the use of bed rails, catheter care and when people fell. A decision had been made to isolate one person due to a health condition. This decision was based on online information rather than health advice and was not appropriately risk assessed.
● We received a mixed response from people about their access to healthcare services. Some said they did not see a GP when they wanted to. Staff said a number of GP surgeries supported people living at the home. They said some GPs were more proactive than others in visiting and reviewing people's care needs and medicines. Staff said they also regularly had to chase prescribed medicines from the pharmacy; this was the case when we inspected in connection to a person's pain relief.

Adapting service, design, decoration to meet people's needs
● Prior to the inspection, the provider had already put in place plans to improve the appearance of the home, including replacing carpets in communal areas. Bedrooms had been decorated and communal areas. A relative said, "They have re-decorated mum's room and are going to do the others and they asked what colours mum would like and it was done to her personal taste." A person living at the home described their room as "ideal".
● A new lift was due to be fitted, and work had taken place to address issues with the delays in hot water

reaching people's rooms. People told us they used the garden, which included a large patio and lawn, when staff were available to accompany them. The providers said they were committed to improving the environment for people living at the home.

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

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

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

● Steps had been taken to protect people's rights. DoLS applications had been made for 4 people living at the home. These were linked to the use of bed rails or where a person lived. However, for one person bed rails posed a risk of harm to them, and for other people the lack of security of the building was a potential risk to their safety. A relative said they "could walk straight in" and were often not seen by staff. Following CQC feedback, actions were taken to make the building more secure, including moving a staff member to an office by the front door and installing a keypad on relevant doors. Bed rails for one person were removed as they posed a risk to their safety.
● The interim manager identified information linked to legal decisions around people's health and welfare was not clear in records. This meant the wrong people might be consulted to make decisions for people no longer able to make informed choices. The interim manager took action to ensure information was appropriately recorded so staff were clear who to consult.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The registered manager explained how they assessed people before they moved to the home to ensure their care needs could be met. They said they then discussed this information with the care co-coordinators. However, during the inspection, we saw staff were struggling to meet the needs of one person whose communication style was impacting on the well-being of others. Staff told us they were concerned they couldn't meet the person's emotional needs as they did not have the time or for some staff the experience. The interim manager subsequently met with the person's representative to support them with finding a home that could meet their needs.

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 good. 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.

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

- The culture and the way the home was managed left staff feeling unsupported and overwhelmed at times. Staff were working additional hours to cover sickness, vacancies and absences; they were demoralised and saddened by the negative changes in the atmosphere and the management of the home. Shortly before the inspection, some staff had met with the provider to share their concerns; other staff who felt insecure about their work status said they were more reluctant to share their worries.
- When a new electronic care system was implemented at the request of the registered manager, staff were not supported appropriately when it was installed. The registered manager went on annual leave when the new system went 'live' in 2022. This left care coordinators to manage and run the home in the registered manager's absence, as well as train the staff team in the new system. Staff described how difficult this period had been.
- During the inspection, we saw staff go to the care co-ordinators with their concerns. Staff told us they did not find the registered manager approachable. Some staff described feeling bullied and were fearful of losing their job. The staff team relied heavily on each other for support rather than feeing supported by the registered manager or nominated individual. However, a recent meeting with the provider had made some staff feel action would be taken to address their concerns.
- Despite being short staffed on our second day of inspection, the registered manager was not initially working on the floor to assist staff or oversee the deployment of staff to help prioritise the care needed. For example, the serving of breakfast was delayed. It was left to the care coordinator to run the shift, whilst was also trying to administer medicines and answer the phone, which was potentially unsafe and could have caused errors. We raised our concerns with the registered manager about being based in their office; they later told us they had helped staff by making some beds.
- Poor management of staff training meant action had not been taken to performance manage staff who were not fulfilling their allocated tasks or who had not completed relevant training to their role. This meant there was the potential risks to the safety of people living at the home.

The management arrangements were not effective to ensure good governance of the service. This placed people at risk of harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● There were poor governance arrangements and oversight. This meant the risks of malnutrition, dehydration, lack of mental and emotional stimulation, poor personal care, staff training and environmental risks had not been identified or addressed.
●The provider had recruited an experienced manager and nominated individual, and we saw evidence of a thorough recruitment process. However, one application form had not included relevant information which might have impacted on their choice of candidate. This came to light during the inspection.
● There were ineffective systems and processes to monitor the work and performance of the registered manager. Despite regular visits by the nominated individual, ineffective action was taken to address the registered manager's performance.
● The provider did not have effective oversight of the care provided which meant they failed to comply with regulations, so people were at potential risk of harm.
The oversight arrangements were not effective to ensure good governance of the service. This placed people at risk of harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●The registered manager and nominated individual have both resigned. The manager is no longer registered with CQC.

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
● Following our feedback during the inspection, the provider took prompt action to contract with a care consultancy company to oversee the management of the home. They adapted their action plan as more information came to light which showed they were responsive and took the concerns seriously. They were upset and shocked.
● Since the inspection, their actions have placed the well-being and safety of people living and working at the home at the heart of their plan to improve the service. They have provided CQC and the local authority with an on-going action plan for the consultants role and a service improvement plan for the home. They have been open and worked alongside external agencies to ensure people are safe and the staff group are well led.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care
● The commitment of the staff team has meant the feedback from people living at the home and people visiting was mainly positive, including the caring nature of the staff, the quality of the food and laundry service and the cleanliness. However, one relative was concerned over the lack of management cover for seven days over Christmas, and several commented on the changes of staff and the reliance on agency staff.
● From talking with people living at the home, most seem satisfied with their care. People who were able to engage in conversation had a view on their experience and had the ability to be involved more in how the home was run to their benefit. Their potential capability to be involved had not been nurtured by the previous governance arrangements.
● Most relatives found the registered manager approachable and felt they were running the home well. However, people did complain the phone was often not answered and one person felt their complaint was poorly addressed by the registered manager, who initially did not respond to them.
● Despite the staff group feeling unsupported, they were committed to working at the home and caring for the people living there. For example, one said "I would recommend this as a good place to work because the staff are amazing, and we all get on. We are all friendly and support each other in work and are also supportive of each other even personally." Since the appointment of the interim manager staff have contacted us to say the atmosphere is positive and they are confident improvements will be made and

sustained.

Working in partnership with others

● Previously advice from external agencies had not been regularly sought with decisions and risks being managed within the service. The interim management team and the provider have now contacted numerous external professionals to ensure people are safe and being appropriately cared for. They have acted on concerns and were open to guidance. As a consequence, future work includes ensuring staff have the training they need to meet the care and emotional needs of people living at the home.

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 Risks were not well assessed, monitored or managed and people were at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Staff deployment had not been managed appropriately to ensure there were sufficient numbers to keep people safe. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The management arrangements were not effective to ensure good governance of the service. This placed people at risk of harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.