Tuella Limited

Brookdale House Care Home

Inspection report

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Date of inspection visit:
22 March 2022
26 April 2022

Date of publication:
06 July 2022

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Brookdale House Care Home is a residential care home providing accommodation and personal care to up to 27 people. The service provides support to older people and people living with dementia. At the time of our inspection there were 22 people using the service, two of whom were in hospital.

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

The systems in place for managing infection control risks were not always implemented safely or effectively. Whilst there were systems in place to monitor the safety of people's care and the environment, these systems were not always effective. This put people at risk of harm. Improvements were needed to ensure that the use of topical medicines was managed safely. The use of covert medicines was not taking place within legal and best practice frameworks. The numbers of staff deployed was insufficient to consistently meet people's needs. Recruitment practices were safe. Staff had received training in how to identify and report any concerns of abuse. There were systems in place to record and monitor incidents and accidents, these were investigated, and any lessons learnt were used to improve care practice.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. People were not offered meaningful choices of meals that reflected their dietary needs. People's care and support needs were assessed before they moved into home and detailed care plans were then developed in line with national best practice guidance. However, this was not always followed by staff. Staff training, induction and supervision was implemented inconsistently. The staff worked with a range of health professionals to ensure people's healthcare needs were met.

We observed that staff sometimes lacked consideration and there was little evidence of truly person-centred support. The management and oversight of the home had been ineffective, and a number of essential standards were not being met. The manager in post was inexperienced. However, robust arrangements had not been put in place to provide them with the support they needed. Systems and processes were in place to help monitor care delivery and the environment; however, these had not always been ineffective. There had been a high turnover of managers and staff and this had had an impact on staff morale which was low. Staff and relatives told us the manager was trying to make improvements and was approachable and helpful.

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 when published in May 2021.

Why we inspected

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We received concerns in relation to the management of medicines, people's care needs, the environment and staffing. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.
For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.
The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.
We have found evidence that the provider needs to make improvements. Please see the safe, effective and well led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

The provider has started to take action to mitigate the risks.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Brookdale House 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; person centred care; consent; safe care and treatment; the environment; good governance and staffing.

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

We have made recommendations that the provider has regard to best practice in dementia care and the environment when completing their refurbishment and that they take account of relevant guidance and local protocols to support safe visiting?

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.

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.	**Requires Improvement**
Is the service effective? The service was not 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**

Brookdale House Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the 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 service was inspected by three inspectors, a specialist adviser and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type Brookdale House Care Home '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. Brookdale House 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, however, whilst they remained in

overall control of the service through remote monitoring, they had not been able to visit the home for some time. A new manager had been appointed in January 2022 but had not yet applied to register with us.

Notice of inspection
This inspection was unannounced.

Inspection on-site activity started on 22 March 2022. Due to an outbreak of Covid 19, we were unable to return to the home until 26 April 2022 which meant completion of the inspection was delayed. We reviewed some evidence remotely during this time.

What we did before the inspection
We reviewed information we had received about the service, such as notifications of events in the home, whistleblowing and safeguarding concerns. We sought feedback from health and care professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We received feedback from two healthcare professionals. We used all this information to plan our inspection.

During the inspection
We sent questionnaires to all staff, however we did not receive any responses. We spoke with four people and four care staff as well as the manager, chef, housekeeper and maintenance person. We reviewed records relating to staff recruitment and supervision as well as records relating to the environment and premises. We looked at three people's care records and pathway tracked two people's care. Pathway tracking enables us to check people have received all the care they require according to their assessed needs.

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.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We spoke with ten relatives.

Requires Improvement

Is the service safe?

Our findings

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

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

Preventing and controlling infection

- The systems in place for managing infection control risks were not always implemented safely or effectively and we were not assured people were protected from the risk of infection.
- On the first day of inspection we found paintwork on handrails and bannisters was worn which would have made this difficult to clean effectively.
- Soiled laundry in red bags was piled on top of people's clothes on the floor in the laundry room.
- Health professionals had also raised concerns about laundry. They visited the home on the 25th April 2022 and saw a laundry basket on the floor in the hall for the two-hour duration of their visit. This is poor practice and did not comply with the provider's own policy for managing soiled laundry.
- There was a notice on the washing machine which stated staff were to use a 30 degree cycle if unsure of the washing temperatures for different items. This would not be sufficient to safely launder soiled items and eliminate bacteria and did not comply with the provider's policy which stated people's clothes should be washed at 40 degrees and soiled bed linen should be washed at 60 degrees.
- Staff wore personal protective equipment (PPE) such as masks, gloves and aprons and guidance was on display around the home to remind staff about how to put on and take off PPE. However, PPE was not disposed of safely or in line with good practice. We noted on the first day of inspection discarded masks and blue gloves lying on the floor in the garden and discarded blue gloves had been placed in open waste-paper bins in the lounge. This had been addressed by the second day of our inspection.
- Guidance at the time was that staff should take a COVID-19 test before each shift. However, two staff said that following their test, they waited in the lounge until their test result was ready. This meant if their test was positive, they had already been waiting inside the home which posed a risk of spreading the infection.

The provider was failing to ensure people were protected from the risk of infection. This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment.

- Government guidance in relation to COVID-19 at the time stated: "Visitors should not enter the care home if they are feeling unwell, even if they have tested negative for COVID-19 and are fully vaccinated and have received their booster. Transmissible viruses such as flu, respiratory syncytial virus (RSV) and norovirus can be just as dangerous to care home residents as COVID-19. If visitors have any symptoms that suggest other transmissible viruses and infections, such as cough, high temperature, diarrhoea or vomiting, they should avoid the care home until at least 5 days after they feel better. Visitors are advised against visiting the care home (for 10 days) if they have been identified as a close contact of someone with COVID-19, unless absolutely necessary, even if they have been fully vaccinated". The inspection team were not screened for

any of these symptoms or asked if we had been a close contact of anyone who had tested positive for COVID-19. The manager told us they had been told they were no longer required to ask this information. The local Clinical Commissioning Group infection prevention and control lead told us that it was good practice to still ask screening questions to help reduce the risk of infection entering the home.

We recommend that the provider review their practice to ensure that all visitors are screened for symptoms of acute respiratory infection and recent contact with positive cases before being allowed to enter the home which is in keeping with best practice and local protocols.

● We were assured that the provider was accessing testing for people using the service and staff.

● 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.

Visiting in care homes

The home had been facilitating open and unrestricted visiting in line with Government guidance and relatives confirmed this. During a recent COVID-19outbreak the home suspended visiting in order to help prevent further spread of infection. When we resumed our inspection, we saw family and friends were again able to visit without restrictions.

Staffing and recruitment

● We had received a number of whistleblowing concerns about staffing levels in the home and explored this during the inspection.

● Some relatives told us there were enough staff. Comments included, "I think they are hard pressed but those they have are very good," and "I think they are very busy but come within a reasonable time," and "mostly, although very busy."

● However, other relatives had concerns. One relative told us, "I think the frequent changes of managers and then staff has meant that there aren't enough to do other than the basics." Another relative said, "She has a shower but would like one more often." A third relative said, "[My family member] is lucky to get one [shower] at all." A fourth relative told us, "I think the basics are done but that is all."

● Concerns were also raised about the numbers of staff deployed at night. For example, one relative said, "At night [my family member] rings for help and no-one comes so she tries to manage alone, which she can't." Another relative commented, "I think she is safe in the day but I have some concerns about enough staff at night."

● We spoke with the fire officer at the fire and rescue service who also had concerns about staffing numbers at night and how staff would be able to evacuate people safely. They had sent the registered manager a 'letter of fire safety matters'. The registered manager had responded to the fire officer to say they felt they had sufficient staffing at night and provided a list of actions they would take to ensure fire safety. The fire officer had requested an up to date fire risk assessment before they could assess the actions as suitable. They were still waiting for the fire risk assessment at the time of writing the report. The registered manager did not agree with our statement about fire safety in the draft report we sent them so we followed up with the fire safety officer on 27 June 2022. They had still not received the up to date fire risk assessment so had not yet been able to assess the actions or close the case.

● We asked for the rota for the weeks we inspected and saw there were two care staff and a team leader on each day shift, and two night care staff to support the 22 people who lived in the home. The team leaders provided care to people, carried out the medicines rounds and updated care plans as well as other duties,

such as liaising with GPs and district nurses. There were two housekeeping staff who worked Monday to Friday cleaning and doing the laundry, and a chef prepared lunchtime and evening meals. The care staff told us when the chef and housekeeping staff were not there, they made people's breakfasts each day and did some laundry and cleaning at the weekends. This meant they were taken away from providing care to people. The manager was recruiting for weekend housekeeping staff.

● Four members of staff told us there were not enough staff. One staff member told us the staffing was "fairly low" and said "There can be [risk] as a result. We've got a few doubles, if we're doing doubles there's pretty much no one around if the team leader is doing meds and something happens. A lot can happen in five to ten minutes". A second staff member said, "They [staffing levels] are no good at the moment. So many people leave, it takes so long to replace them. With two [carers] and a team leader…. If you're full and you've only got two staff it could be a risk I guess. You can't be everywhere at once". Another staff member told us "There are not enough staff. We take it higher but nothing happens. We run the floor with three [staff], people are not always getting showers and baths or activities. They do ask for a bath or shower but there is not always time". On the second day of our inspection we noted a third staff member on shift.

● The manager also raised concerns about staffing levels. They told us, "I have never felt there were enough staff". They said there should be three carers and a team leader on each shift. They told us there were a lot of incidents at night and wanted a night deputy manager and to increase the day staff.

● On the first day of inspection, we heard a person on the first floor calling out from their room for help. Our inspector went to the person and saw them lying on their bed with their legs over the side, at risk of falling to the floor. There were no staff on the first floor so our inspector went downstairs and found a staff member. They went to attend to the person. We asked the manager for the records of incidents and accidents and were shown a graph which showed an overview of accidents, alleged or actual harm and behaviours of concern. We asked the manager for a breakdown of the accidents and incidents but they could not access the detail to show us. We asked for a copy once they had accessed the information, but did not receive it.

● The manager told us they had been working 70 hour weeks to cover some duties, including reviewing care plans, away from the team leaders so they had more time to help out the care staff. On the second day of our inspection however, the manager told us they felt they had stepped in to help too much and had now stepped back and reduced their hours again.

The provider was failing to ensure there were sufficient staff to provide safe care to people. This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment.

Assessing risk, safety monitoring and management

● The provider had systems in place to monitor the safety of people's care and the environment, such as health and safety audits, daily walkabouts and checks. However, these systems were not always effective. This put people at risk of harm.

● Four people had been identified as being at risk of pressure sores and required air mattresses to mitigate this risk. On the first day of the inspection we checked all four mattresses and found one had been switched off and another had been set at the wrong pressure for the person's weight.

● Food, fluid and repositioning charts were used to monitor people at risk of malnutrition, dehydration and skin damage. However, a number of those viewed contained gaps. This meant that we could not be assured that these risks were being safely managed.

● We did note there were some contradictions in one person's care plan about how their diabetes was managed, for example, both diet controlled and insulin controlled.

● Two healthcare professionals raised concerns with us and told us the home did not feel safe due to the issues they had identified when they visited. These included; lack of Covid 19 screening; poor environmental standards and laundry practices, lack of staff training completed (including fire safety), and lack of

appropriate mobility equipment for a new admission.

The provider was failing to ensure people were protected from the identified risks of harm. This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment.

● Despite our findings, relatives told us they thought their family members were safe. Comments included, "Yes, I do feel she is safe," and "I have seen transfers [from bed to wheelchair] which seem safe to me." Another relative said, "Yes, I am happy that she is safe."
● Fire safety checks and staff fire training had not been completed before March 2022 although these were now in hand.
● On the first day of our inspection the external metal fire escape had been covered in moss and leaves. This, and other environmental concerns had been addressed and made safe by the time of our second visit. The maintenance staff told us they had only been recently employed and that there was a backlog of maintenance which would take time to get through. They were clearly committed to raising the standards of the environment.
● The legionella risk assessment review had been due in January 2022 but had not yet been completed. Following the first day of inspection a date had been arranged for this to be reviewed the first week in May 2022.
● Whilst there were still improvements to be made, we were assured by the date of our second visit that the provider had taken sufficient action to ensure that they were meeting essential standards in relation to the environment.

Using medicines safely
● The provider had a policy in place for the management, storage and administration of medicines.
● Medicines were administered on time and spaced out appropriately between doses.
● The controlled drugs (CD) cabinet was checked on the first day of our inspection and the medicines count was correct. Following the first day of inspection some CDs went missing. This was identified through an audit and the provider appropriately notified the police and local authority safeguarding team. The registered manager carried out an investigation which was inconclusive, and they have been unable to identify what had happened to the missing controlled drugs but have strengthened the systems in place to prevent similar incidents from occurring.
● We did note some areas where improvements could be made. Prescribed creams were not stored securely which could pose a risk to people from accidental ingestion for example.
● Creams were applied by care staff but the medicines administration record (MAR) was completed by the team leader which is not in keeping with best practice.
● There was no clear information for staff about when and where to apply creams. Staff told us they 'just know' where to apply the creams. There were entries in care records for two people which stated 'cream applied' but it was not clear when or which creams this related to.

● The provider had robust procedures in place for safe recruitment. We reviewed recruitment records for three new members of staff and found the procedures had been followed which included obtaining a full employment history, references and a Disclosure and Barring Service check. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse
● All but one member of staff had received training in how to identify and report any concerns of abuse. This

was completed on-line by staff who told us they also had access to relevant policies and guidance. One member of staff told us they had still to complete their training and was unsure of who to report abuse to outside of the home but would ask for advice if needed. We spoke to the manager who confirmed deadlines had been given to staff to complete their training.

● Staff understood the whistleblowing policy and said they would be confident to use it if they needed to.

Learning lessons when things go wrong

● The provider had systems in place to record and monitor incidents and accidents. The manager told us they could access reports to review any trends or themes.

● Incidents were investigated, and any lessons learnt were used to improve care practice. For example, after one incident, the registered manager had written to staff informing them a member of staff was to be allocated to sit in the dining room at mealtimes. We saw this happened on the days we were in the home.

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 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.

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.

- The provider did not always work within the principles of the MCA.
- The use of covert medicines was not taking place within the context of legal and good practice frameworks including the Mental Capacity Act 2005. For example, one person did not have a mental capacity assessment and best interest consultation documented to support the use of covert medicines. The manager could not show us evidence that the GP had been involved in the decision to administer the medicines covertly.
- We also saw examples where consent for care had been sought from relatives or third parties without it being clear that they had the legal authority to provide this consent. Where relatives do not hold a Lasting Power of Attorney for health and welfare they have no legal status to give consent for decisions relating to the care and treatment a person receives. This meant people's rights were not being protected.
- The manager did not understand their responsibilities under the MCA and were not aware they could complete MCA assessments. They felt this was the responsibility of other health and social care professionals.

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.
- The manager did not understand that a DoLS can only be applied for someone who lacks the mental capacity to consent to any restrictions. For example, one person, with mental capacity, made a choice to have bed rails on their bed to reassure them and help them feel safe. The manager told us they were

applying for a DoLs to authorise this.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Consent.

Adapting service, design, decoration to meet people's needs
● The environment was not being maintained to ensure that this remained a pleasant place for people to live.
● We were not assured that sufficient efforts had been made to secure contractors to address areas where the environment needed to be improved. For example, the seat on the chair lift on one stair-case was broken so would not clip up. This meant it protruded across the stairs, reducing the width available to pass. We were concerned that increased the risk of people falling. On the first day of the inspection we observed one person walking downstairs sideways so they could get past the seat. We were concerned about the risk of a fall as they looked precarious so we asked a member of staff who told us, "She can be." They went to help but the person was already at the bottom of the stairs.
● We found a long screw protruding from a piece of wood in the lounge causing a risk of skin tears. This was later addressed.
● The garden had been neglected and was in a very poor state. For example, broken pots were covered by fallen leaves alongside the pathways. Broken furniture was propped up against walls. Flowerpots were used by staff as ashtrays and were full up with cigarette ends. A wheelbarrow was half full of green stagnant water.
● Relatives also raised some concerns about the environment. Comments "It needs some general tidying up, but it seems clean," and "It could do with a lick of paint here and there," and "nothing smells of urine anymore, but the curtains are hanging off."

Failure to properly maintain a secure, safe, clean environment is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Premises and equipment.

● The registered manager had not been aware of the concerns we found. When we sent them photographs of the environment, they said they would address our concerns promptly. On the second day of our inspection we found improvements had been made to the garden area which had been tidied up and rubbish removed. Seating areas had been created with new furniture and plants.
● They also advised that there was a refurbishment programme underway which included redecorating bedrooms and replacing carpets. This was confirmed by relatives when we spoke with them. For example, one relative said, "The decorating is on-going," and "It is clean, and the decorators have been in," and "the carpets look new."
● It was also planned that as part of the refurbishment programme that the ground floor would be reconfigured to open out the space and provide a larger dining room and lounge which will enable people more space and flexibility for seating arrangements.

We recommend that the provider take account of national best practice to ensure that the refurbishment of the home ensures the physical environment is supportive of people living with dementia and other sensory deficits and enables them to safely and have meaningful interaction with the environment in which they live.

Supporting people to eat and drink enough to maintain a balanced diet
● Improvements were needed to ensure that people's nutritional needs were being met.
● Some people required specific diets to maintain their health, but we were not assured these were always

followed appropriately. For example, where people required a high fibre diet, food charts did not always reflect this. We spoke with the manager who told us people could choose what they wanted to eat, and this may not always be in accordance with their care plans. However, there was no evidence to demonstrate staff were offering or encouraging people to eat high fibre food options where identified.

● We observed two lunch meals and found the experience could be improved for people. The lighting in the dining room was dim and on the first day of inspection the menus on the table had not been changed from the day before. On the second day of inspection we saw people were given their meals without any explanation of what it was.

● Whilst the chef told us they would prepare alternative meals for people and would provide snacks if asked, this is not what we saw happened in practice, for example, people who did not like, or did not want their meal were not offered an alternative main meal but were offered their dessert.

● Staff did not adequately interact with people during mealtimes which was a missed opportunity for social interaction.

● The chef told us they had a good budget for food and prepared everything from scratch. They were knowledgeable about who had any allergies or required specific diets and prepared meals accordingly including preparing diabetic cakes and biscuits.

● We noted some good examples of responding to people's individual food and drinks choices. For example, in one person's food chart they had asked for and received a small cheese and ham sandwich at 11.30pm. At one lunch meal we observed a person had been offered their favourite beer to have with their meal.

● Feedback from people and relatives about the food and mealtime experiences was mostly positive. One relative told us, "Mum says it [the food] is very good." Another relative said, "Mum always says she loves the food," and a third relative said, "She likes meat and two veg and that is what she is having so she likes it." A fourth relative said, "[although very bland] she enjoys it and clears her plate and they make sure her diabetic restrictions are observed."

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

● People's needs were assessed before they moved into the home to ensure their needs could be met. The assessments included all aspects of the person's health; For example, medical history, mobility, skin integrity, eating and drinking, continence and communication.

● A detailed care plan was developed once a person had come to live at the home which provided guidance for staff in how to care for them safely and effectively.

● People were involved in developing their care plan, where possible, along with their family members who knew them well and could share important information such as their likes, dislikes, preferences and life histories.

● Care was assessed and provided in line with recognised national good practice guidance. For example, the Malnutrition Universal Screening Tool (MUST) for people at risk of malnutrition, and the Waterlow assessment for people at risk of poor skin integrity.

● However, the provider could not always evidence care plans were being followed in practice, for example where air mattresses were not set correctly, or meals which did not reflect identified need.

Staff support: induction, training, skills and experience

● We had received concerns about the quality of training before the inspection. Further concerns were identified during the inspection in relation to the induction and training provided.

● Two staff told us they had shadowed other staff for a short period of time during their induction but had not felt this was sufficient or robust enough. One staff member said they had not been shown care plans or how to assist people with washing and dressing so felt it was "pointless."

● The registered manager told us they had improved the arrangements for agency staff inductions with the

new care agency. Agency staff would now need to complete induction training before being allowed to start work at the home so they would be more knowledgeable and effective from the start.

● We spoke with the manager about the support and induction they had received. They told us it was via video meetings and phone calls with the registered manager. Whilst the manager felt supported when we first spoke with them, we were not assured the level of induction and support was appropriate for a manager new to a management role and who was working in isolation within the home.

● The manager maintained a training matrix to track which training staff had completed and which they still needed to do. However, this was difficult to interpret as it included staff from another of the provider's service and it would therefore benefit from being divided into two separate documents to aid clarity. This showed staff received a variety of relevant training and this was mainly completed on-line.

● Some staff felt that online training did not suit their learning style. For example, one staff member told us, "Just e-learning, we had fire training but apart from that no face to face, no hoist training, no meds." Another staff member said, "I prefer hands on [training], you take it in more. It's all been on-line. We've done manual handling on [video] so the lady watched us while we were doing it."

● A staff member also raised concerns about being expected to do their training on shift when they did not have time as they were short staffed.

● However, staff were confident the manager was trying to improve training opportunities. One staff member said, "[Manager] is really good at the moment, she's getting all these courses. I'm just doing level 2." Another staff member told us first aid training was being arranged which the manager confirmed had been booked.

● Some of the new staff had still to complete their essential training but the manager had now given them a deadline for this to be done.

● Staff supervision sessions took place although records showed this was not carried out consistently and this is an area for improvement. Two staff said they had not received supervision and one staff member said they received supervisions every three months but had not found them very effective.

We recommend the manager receives training in how to facilitate effective supervisions and schedules these in advance with staff.

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

● Records showed people had access to community health professionals such as chiropodists , district nurses and GPs and this was confirmed by the relatives we spoke with. Their comments included, "Yes they do. [Name] sees the chiropodist regularly and the GP when needed," and "Yes, they are observant and call the doctor and then tell me," and "[Name] sees all the health professionals booked by the home."

● An external health care professional had been booked to deliver training to staff in the use of a national monitoring system to improve health outcomes for people. This is designed to support homes and health professionals to recognise when a resident may be deteriorating or at risk of physical deterioration, and act appropriately. They told us there had been an over-use of emergency services rather than the 111 or telemedicine services and hoped the training would help staff to develop skills to better manage people's health concerns. Telemedicine is a telephone service where staff can call and ask for advice about people's health concerns. It aims to reduce the reliance on emergency services where this is not appropriate, however referrals for emergency care can be made through the service if assessed as required.

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

● We observed people were treated with kindness most of the time and relatives confirmed they were happy with the way their family members were treated. However, there were instances where staff lacked consideration and there was little evidence of truly person-centred support.

● One person was sitting in the dining room and had become very distressed about another person. As they walked by, staff told the person that the other person? was fine and just having a nap. Whilst staff acknowledged the person, they did not take time to sit with them or provide reassurance. Our inspector sat with the person and listened until they became slightly reassured.

● A staff member had been allocated to cleaning duties and had switched on the vacuum cleaner in front of a person sitting in a chair chatting to our inspector. The staff member had not asked if it would be okay to vacuum or explained what they were going to do. The person was visibly startled. The person was unable to continue their conversation with our inspector due to the noise. When we spoke with the manager about this they said the cleaning needed to happen, and did not seem to understand it would have been considerate to at least let people know and check with them first.

● The neglected state of the garden when we first visited meant people could not exercise their choice to, or be encouraged, to go out and enjoy the garden during the period of good weather as it was not safe.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, person centred care.

● People were sitting around the TV, which was on, in the lounge although most people were not watching it. One person told us they had not been asked if they wanted to watch TV and said they would prefer to do something else.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, person centred care.

● Despite the concerns we found, relatives told us they thought the home was a happy place and the staff were friendly and helpful. Comments included, "It is a happy place and we have discussions with the staff who are very helpful," and "they are a friendly caring bunch," and I think they are genuinely caring, nice people."

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

● We were concerned about the high level of turnover of managers at the service and identified concerns about the level of oversight from the provider.
● The home had a manager registered with the Commission. They were also one of the directors of the company. Due to the high turnover of managers, they had taken on the role of registered manager until they were able to recruit another manager.
● The current manager had been in post since January 2022. They had joined the service in December 2021 as a deputy manager, however when the previous manager left after only a few months in post, they were asked by the registered manager to step up as the manager. The manager told us they had agreed to this although they had never been a home manager before and had stated they would need a lot of support.
● The current manager displayed a commitment to their role and to improving the service and they had received support from the registered manager by phone and video calls. However, since December 2021, the registered manager had been unable to visit the service. Neither they or the provider had, as a result, put robust arrangements in place to provide adequate support to the manager or to ensure themselves that the manager had the skills knowledge and experience to perform their role.
● The manager was not always able to access or provide information we requested.
● Information was retained electronically, and the manager struggled to find the right documents and, in some cases gave us out of date information.
● Record keeping was inconsistent and records had not been stored securely breaching people's rights to expect their personal information to treated confidentially.
● There was a lot of discrepancy between what we had fed back to the manager and what they had had in turn fed back to the registered manager.
● The provider and registered manager had not taken sufficient action to instil a culture where staff felt valued.
● On the first day of inspection the manager told us they had been working 70 hour weeks to support the care staff due to the workload. When we raised this with the registered manager, they did not acknowledge our concerns or have concern for the manager. Their response was it was not a 40 hour a week job.
● On the second day of inspection, the manager was clearly unwell but told us they had to be at work as there was so much to do. They had taken annual leave the previous week but said they had been told they still had to complete daily audits. They had also been on call and had had to liaise with the police about an incident. One staff member told us, "I think they need to sort something out with an assistant or something, supporting the manager. She's quite run down. Last week she was on annual leave but was working. It's unfair, no-one to take over or help her out."
● Staff told us there was low staff morale in the home. There had continued to be a high turnover of managers which had been unsettling and difficult for staff. They told us, each manager had different ideas of how they wanted things done and things were always changing. One staff member said, "Managers are coming and going, it's depressing. Things pick up then fall down. It's quite sad. We've had trouble with staff and maintenance. Staff come and go." Another staff member told us, "Morale is up and down. [Staff] whinge a lot but don't really say anything. At the team meeting yesterday, no one really addressed any concerns so, things like that, nothing gets done." A third staff member said, "Morale is a bit low at the moment because of the lack of staff."
● The registered manager understood their responsibilities under the duty of candour however; one relative was not so positive and said there had been a three to four day delay in informing them about their family member's fall.
● The home had a history of breach of regulations and although at the last inspection in May 2021 it was

rated good, at the three previous inspections in November 2017, November 2018 and January 2020 (rated inadequate in safe) it was rated as requires improvement. We were not assured the management team always learnt from past inspections as they have been unable to sustain a good rating.

Failure to maintain effective leadership and governance arrangements, failure to identify and address concerns, not keeping people safe, protecting their rights and ensuring good quality, person centred care and support is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good governance.

● We inspected the service because we had received a number of whistleblowing concerns and had other concerns raised with us by health and social care professionals. Due to their concerns, the local authority has placed the home under their quality monitoring programme and is supporting the registered manager and manager to make improvements.
● To help drive improvements, the registered manager had employed a quality manager to support the provider's services. They would be spending two days a week at the home, supporting the manager and developing the quality of the service.
● The service recently had a mock inspection carried out by an external consultant and an action plan had been put in place.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others; Continuous learning and improving care
● We observed people were asked on a day to day basis how they were and what they would like to do but did not see evidence of any formal surveys to obtain their views about their care.
● Relatives told us they were not asked by the management team for their feedback about the service. One relative said, "Only you [have asked], and the last CQC visit."
● The manager was trying to involve staff and listen to what they had to say. Staff meetings were taking place where staff were able to share information and bring up any issues they had, although one staff member told us staff did not speak up at meetings.

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 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to provide good quality, person centred care in line with their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to act in line with the principles of the MCA which had not protected people's rights.

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 protect people from the risk of avoidable harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had failed to maintain a clean and safe environment.

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 maintain effective

leadership and governance arrangements, had failed to identify and address concerns, had not people safe, protected their rights and ensured good quality, person centred care and support.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure there were sufficient staff to provide safe care to people.