Lakeland Care Services Limited

Holmewood Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Holmewood Residential Care Home is a residential care home providing personal care to up to 26 people. The service provides support to older people. At the time of our inspection there were 22 people receiving personal care at the service. Holmewood Residential Care Home accommodates people in one adapted building.

People's experience of using this service and what we found
People were at significant risk of harm as safety was not prioritised by the provider. People were not safeguarded against the risk of abuse. We requested GP visits for 4 people we were concerned had experienced and were at risk of neglect. Health and safety risks, such as risks linked to equipment and the environment were not always identified or managed.

People experienced poor symptom management and pain as a result of how medicines were managed. Medicines systems did not support their safe use. People were at risk due to poor infection prevention and control practices within the home, including PPE not being stored and disposed of safely and hygienically.

The provider did not ensure there were sufficient numbers of staff with the right skills to keep people safe. People's requests for assistance from staff via the call bell system were not always answered or reassurance provided. Some people had stopped pressing their call bells due to this. Safe recruitment processes were not followed to ensure staff were suitable for working in the home.

People did not experience effective care. Staff did not always have the knowledge, skills or experience to provide people's care. People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support good practice.

People were at risk of not receiving enough or appropriate nutrition and hydration. People were given meals that were not appropriate to their specific nutritional needs. The service did not always work effectively with health and other professionals. The lack of an effective working relationship with the local GP surgery meant people's health needs were at risk.

The service was not suitable for the needs of the people living at the home. The premises were not designed with people's specialist needs in mind, including dementia.

People did not receive kind, compassionate care. On occasions, people were crying as they had not received assistance they needed. People were not treated with dignity or respect. People's continence products and supplies were left in public areas of home.

People's care was not person-centred. People were at risk of social isolation as they had few opportunities

for stimulation and to speak with others, including staff members. The service was not inclusive, people's communication needs were not considered or accommodated. People were not consulted in involved in making decisions about activities planned at the home.

People were at risk due to significant shortfalls with the governance and oversight of the service. Processes were not established to monitor quality and safety across the service. The registered manager was not accepting of the issues we found on inspection and did not always understand the risk to people. A culture had been established at the service of organisational and institutionalised care, where people did not experience good outcomes.

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

Rating at last inspection and update
The last rating for this service was requires improvement (1 December 2022). This service has been rated requires improvement or inadequate for the last 2 consecutive inspections.

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

At our last inspection we recommended that the provider review and update their visiting policy and review the specialist types of care provided at the service. At this inspection we found improvements had been made to visiting. However, the provider had failed to review the specialisms provided at the service.

Why we inspected
This inspection was prompted by a review of the information we held about this service.

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

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

We have found evidence that the provider needs to make improvements. Please see the full report. You can see what action we have asked the provider to take at the end of this full report.

Enforcement and Recommendations
We have identified breaches in relation to person-centred care, dignity and respect, need for consent, safe care and treatment, safeguarding, meeting nutritional and hydration needs, premises and equipment, good governance, staffing and fit and proper persons employed. Please see the action we have told the provider to take at the end of this report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when

we next inspect.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not caring. Details are in our caring findings below.	**Inadequate**
Is the service responsive? The service was not responsive. Details are in our responsive findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Holmewood Residential 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
This inspection was carried out by 2 inspectors and 1 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
Holmewood Residential Care Home is a 'care home' without nursing care. People in care homes receive accommodation and personal care as a single package under one contractual agreement dependent on their registration with us. 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 CQC 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.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 20 July and ended on 16 August 2023. We visited the service on 20 July, 2 August and 7 August 2023.

What we did before the inspection
We reviewed information we had received about the service. We sought feedback from the local authority 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 used all this information to plan our inspection.

During the inspection
This inspection was carried out by conducting site visits and speaking to staff remotely. We spoke with 13 people who used the service and 8 relatives/ friends of people living at the service about their experiences of the care provided. We spoke with 22 staff, including the nominated individual, provider representatives, registered manager, deputy manager, supervisors, care staff, chef, activities coordinator and maintenance worker. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included 13 people's care records. We looked at multiple medicines records. We reviewed 3 staff recruitment and supervision records. A range of records relating to the management of the service, including accidents and incidents, staff training, health and safety records, audits and a sample of the provider's policies and procedures were also reviewed. We received feedback from 6 health professionals that worked alongside the service.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question inadequate. At this inspection the rating has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to assess risks to people's health and safety and take action to reduce these risks. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 12.

- People were at risk as there was limited or no action to assess, monitor and improve safety.
- Information about risks to people was not always effectively assessed, monitored or managed. This included risks linked to falls, expressive communication (behaviours that challenge) and skin integrity.
- The provider did not always assess and properly manage environmental and equipment related risks. For example, there was an attic area on the second floor of the home, accessible by a narrow staircase, one of the stairs was damaged. Access to the attic had not been secured to prevent people accessing this unsafe area.
- High water temperatures in cold water outlets created the potential for legionella growth. Control measures were not in place to manage this.
- Equipment used to support people was not always risk assessed or used safely. A wheelchair platform lift was in use to enable wheelchair users to access a mezzanine level from the first floor of the home. This equipment had not been risk assessed and staff not received guidance on how to operate it safely.
- Wheelchair transfers were not always managed safely. For example, staff did not always ensure people's feet were secured and lap belts used to prevent harm or injury.
- The call bell system used in the home was not fit for purpose. The system was used by staff to identify where to locate people that had pressed their buzzers for assistance. There was only 1 call bell panel in the home that covered all areas of the home. This was located in the supervisor's office, which was not easily accessible to care staff to enable them to identify who was requesting assistance. Staff used walkie-talkies to communicate with each other. This system was not effective. Inspectors were having to tell staff which buzzers were activated to enable them to respond.

We found no evidence that people had been harmed. However, the provider failed to assess and mitigate risks to people. This placed people at risk of harm. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following our feedback, the provider advised they would arrange for the call bell system to be replaced

and an additional member of staff available on all shifts to help identify which call bells had been pressed until this had been completed. On day 3 of the inspection, we found the additional staff member had been absorbed into the staff numbers and was not carrying out this function.

Using medicines safely

At our last inspection the provider had failed to ensure the proper and safe management of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 12.

● Medicines systems were not safe and did not support their proper use.
● The provider failed to ensure people had an adequate supply of medicines prescribed to meet their health needs effectively. One person was anxious about running out of medicine and the impact this would have on them, this affected their health and wellbeing. The person said, "I hope my [medicine] has come, they had run out yesterday, my leg is so sore."
● People did not always receive their medicines as prescribed. Pain relief was not always administered to people as prescribed, leaving people at risk of poor symptom management and in pain.
● People did not always receive their medicines in a timely way. One person was reliant on their medicines to control their symptoms and enable them to be more independent. On day 2 of the inspection their medicine had been given late, affecting their mobility and dexterity.
● Medicines were not disposed of safely to ensure all medicines were accounted for and stored securely.

We found some evidence that people had been harmed. The provider failed to ensure the safe and proper management of medicines. This placed people at risk of harm. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following our feedback, the provider arranged for a review of the medicines system in place and for staff competencies to be re-done to improve safe medicines practices.

Preventing and controlling infection

At our last inspection the provider had failed to assess and manage infection risks. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 12.

● People were at risk because of poor infection prevention and control practices.
● PPE was not stored or disposed of safely and hygienically. For example, gloves and aprons were not easily accessible to staff. When staff reached for these, aprons and gloves fell out of their storage containers on to the floor. Staff were observed returning PPE that had been on the floor back into their containers. This created a contamination and infection risk.
● Equipment used to support people was not kept clean or stored appropriately. On day 2 of the inspection a falls sensor mat was observed being used for a person. The falls sensor mat was dirty and stained.
● Safe food hygiene practices were not always followed by staff. For example, one staff member took a

person's meal and placed it on another person's bed. The person's meal was not covered. This put people at risk of infection from potential food contamination.

We found no evidence that people had been harmed. The provider failed to assess and prevent the spread of infections. This placed people at risk of harm. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following our feedback, we saw food coverings in use on subsequent days of our inspection.

Learning lessons when things go wrong
● The registered manager and staff did not always recognise concerns, incidents or near misses.
● There was little evidence of learning from events or taking action to improve safety. For example, when medicines errors occurred, we were not assured thorough and complete investigations were undertaken. Investigation records did not always record the name of the medicine or the dose.
● People's care records and dependency levels were not always reviewed following accidents and incidents, such as falls, to ensure all appropriate measures were in place to minimise risks to people.

We found some evidence that people had been harmed. The provider failed to do all that was practical to reduce risks to people. This placed 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

At our last inspection the provider had failed to ensure there were sufficient numbers of staff to support people safely and effectively. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 18.

● The provider did not always ensure there were enough staff with the right mix of skills to support people to stay safe.
● The provider did not always have an appropriate system in place to identify staffing levels needed. The provider used a dependency tool to determine how many staff were needed. We found 2 people missing from the dependency calculations on day 1 of the inspection. Full information about people's needs and the layout of the home was not being added to the dependency tool or considered to inform staffing decisions.
● Staff did not always respond to people's call bells or requests for help in a timely way. This caused people distress and put them at risk of harm.
● The provider did not ensure staff had the mix of skills and experience needed to meet people's needs. On day 2 of the inspection, a new member of staff was shadowing an agency care worker, who had limited experience of working in the home and people's needs. This put people at risk of not having their needs met appropriately.
● Following our feedback the provider told us they would include an additional staff member on all shifts until work had been carried out to improve the call bell system. We found additional staffing was not always happening.
● People and their relatives consistently told us there were not enough staff. Comments included, "You could do with a few more care staff some days. They are rushed off their feet." and "It can be really bad at

weekends, they [care staff] are run ragged."

We found no evidence that people had been harmed. The provider failed to ensure there were sufficient numbers of staff that were suitably qualified, competent and skilled. This placed people at risk of harm. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection the provider had failed to ensure appropriate checks were carried out prior to recruiting staff. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 19.

● Systems were not always safe or robust to ensure suitable staff were recruited to work in the home with vulnerable adults.
● Staff did not always complete application forms to inform decisions about their suitability for care work. Inconsistent information provided as part of the recruitment process was not always identified or explored to inform recruitment decisions.
● Professional references were not always obtained to assess if staff were of good character.
● People were placed at risk of receiving care and support from unsafe and unsuitable agency staff as systems were not in place to support the safe use of these staff in the home. For example, the registered manager did not request detailed agency profiles to understand agency staff training, skills and experience prior to working at the home. Agency staff arrived at the service without ID documents or a uniform to identify them. Supervisors told us they were not always familiar with agency workers or able to identify them.
● The provider could not be assured agency staff carrying out additional responsibilities in the home, such as medicines support, had the knowledge, experience or skills to carry these out safely. For example, on day 3 of the inspection an agency care worker was being trained to administer medicines; a role the provider expected staff with additional training and experience to undertake. The agency worker tried to give medicines prescribed for a different person, an inspector intervened to manage this risk.

We found no evidence that people had been harmed. The provider failed to ensure there were sufficient numbers of staff that were suitably qualified, competent and skilled. This placed people at risk of harm. This was a continued breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● People were at risk of abuse by neglect as systems were not in place or followed to protect them.
● People were at risk from their health conditions not being managed, injuries and unsafe end of life care. We requested a GP visit for 3 people during day 2 of the inspection and made safeguarding referrals.
● Staff told us they did not feel everyone living at the service was safe or having their care needs met. One staff member said, "It's only a matter of time before [person] has a really serious fall and it could be life threatening."

We found some evidence that people had been harmed. The provider failed to ensure people were protected from abuse and improper treatment. This placed people at risk of harm. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Although most people told us they felt safe at the service, they were concerned about when their requests for assistance would be met. One person said, "Safe? I suppose so but they can be busy. I only pushed the buzzer once and they never answered, so I don't bother."

Visiting in care homes

At our last inspection we recommended that the provider review and update their visiting policy and make this available to visitors. At this inspection we found improvements had been made.

● Friends and family members were able to visit people living at the home and spend time with them.

Inadequate

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 inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

At our last inspection the provider had failed to ensure staff providing care to people had the qualifications, competence, skills and experience to do so safely. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 18.

- Staff were not adequately training. Many staff did not have the skills, knowledge and competence required to care out their roles safely.
- Staff did not always have the necessary skills, experience or training to provide clinically delegated tasks, such as stoma care and oxygen therapy. There were people living in the home with these care needs. Clinically delegated tasks are nursing tasks, which care staff can carry out if they have received training and had their competence assessed to provide these.
- Supervisory staff did not always have the knowledge, skills and experience to support other care staff. For example, some supervisors had not received training, including in delegated tasks to ensure these were carried out safely and appropriately.
- No managers, care staff or supervisors had received training in end of life care to equip them with the knowledge to provide this support. One person at the time of our inspection was receiving end of life care at the home.
- Kitchen staff were not always trained in areas relating to their role. For example, only 1 out of 4 kitchen staff had completed diabetes training, despite people with diabetes living at the home.

We found no evidence that people had been harmed. The provider failed to ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced staff. This placed people at risk of harm. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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).

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

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 ensure people's consent was obtained. Managers were unclear about requirements relating to consent.
● Relatives had signed consent forms for receiving care and having photos taken on behalf of people, without the provider considering or assessing people's capacity to make decisions.
● DoLS requirements were not understood to protect people's rights. Managers did not highlight high risk DoLS applications to the local authority in-line with local authority advice, for example, for a person that had made attempts to leave the home. They also did not submit an urgent DoLS authorisation.
● The provider did not check or keep records of representatives legally authorised to act on people's behalf, for example, Lasting Power of Attorney documents. This put people at risk of not having their representatives consulted or able to make best interests on the behalf. Alternatively, people were at risk of their representatives making decisions on their behalf without the legal authority to do this.

We found no evidence that people had been harmed. The provider failed to ensure consent was obtained from people and the MCA was followed. This placed people at risk of harm. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● People were at risk of poor monitoring and management of food and fluid intake. The provider did not ensure people always had enough to eat and drink throughout the day or had appropriate food and drink to meet their dietary needs.
● Risks linked to people losing weight were not always managed. For example, one service user had lost 9kg over a 7-month period. Despite records showing the person had not always been eating or drinking sufficiently and had missed meals, the provider had not reviewed or acted on this information.
● People were served meals and snacks that were not appropriate to their specific dietary needs by staff that did not know people's needs. This placed people at risk of choking and not having their nutritional needs met. One staff member said, "I don't think the different needs for food are catered for. There isn't much choice for diabetic puddings."
● Information about people's specific dietary needs was not recorded accurately or consistently within the service. Following day 1 of the inspection we told the provider to address this. Inaccurate information continued to be displayed in the kitchen on days 2 and 3 of the inspection.
● People's hydration needs were not always met. Juice drinks were available in the lounge. However, there were no cups, glasses or beakers available for people to use. The juices were dated from the previous day and incorrectly labelled.

We found no evidence that people had been harmed. The provider failed to ensure people's nutritional and hydration needs were met. This placed people at risk of harm. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● On day 3 of the inspection a provider representative addressed the inaccurate and inconsistent dietary needs information displayed in the kitchen and started to introduce changes to ensure people's specific dietary needs were catered for.
● People's meal time experiences were not always positive. For example, one person told us, "The food is not nice, no we don't get a choice, no-one asks what you want."

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

At our last inspection we recommended that the provider reviews the specialist types of care provided at the service and ensure staff and the home environment are able to meet these needs. At this inspection we found improvements had not been made.

● The provider had chosen for the service to specialise in supporting older people. People were being admitted and remaining at the service with a range of other needs, despite the provider not adding these specialisms to their registration. These specialisms included sensory impairments, physical disabilities and dementia.
● Full care records for people were not always completed for in a timely way following their admission. Without this information, care staff did not have full details of people's care needs or guidance on how to meet these.
● Staff had not always received sufficient training or information about people's needs to complete their care records. One supervisor told us, "We're asked to do care plans for new residents but we're not given the information to do it."
● People told us they were not always offered choice. One person said, "They don't ask me what I want."

We found no evidence that people had been harmed. The provider failed to provide person-centred care that had was appropriate, met people's needs and preferences and involved them in designing their care. This placed people at risk of harm. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following our inspection visits, the provider made changes to their service specialisms with CQC, although we were not assured changes had been made at the service to meet people's needs.

Adapting service, design, decoration to meet people's needs
● The home environment was not suitable for the needs of people living at the service. There were ramps inside the home, which were not marked. This presented a falls hazard.
● There was limited signage around the home making it difficult for people to navigate the home.
● The cleaning trolley containing cleaning materials and products used by domestic staff was not always secured or stored appropriately. The cleaning trolley was not lockable, to prevent people accessing cleaning products. On day 3 of the inspection, the cleaning trolley was blocking a corridor, preventing a person accessing communal areas of the home. With no staff available, the person had started to push their walking aid into the cleaning trolley, putting them at risk of falling.
● The home was not fully accessible to people living there. Bathing facilities were not accessible to all people. One staff member told us, "I don't think they have adaptations there at Holmewood to enable [person] to have a bath."

● People were not given the opportunity to make decisions about the home environment, including decorations.

We found no evidence that people had been harmed. The provider failed to ensure the premise was suitable for the needs of people living at the home. This placed people at risk of harm. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● People's care and support was not properly planned or coordinated by the provider.
● We were not assured accurate and complete information was always shared with other professionals to inform their response and advice.
● The provider had not established an effective working relationship with the local GP surgery. We were not assured people experienced positive outcomes regarding their health. Following our feedback, the provider told us they would seek to address this in collaboration with the GP surgery.
● Updates and changes to people's health needs were not always shared with health professionals to support effective partnership working and ensure people's health needs were met. For example, one person had experienced a number of falls, although they had been seen by emergency health professionals, there was no evidence their GP had been informed or any follow up health appointments arranged.
● The lack of staff meant staff were not always available to provide health professionals with information or assistance they needed. One health professional said, "They are understaffed. The staff will say there aren't enough. It can mean staff are busy if we need them."

Inadequate

Is the service caring?

Our findings

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

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

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- The provider's practices and established ways of working did not promote kind, respectful or compassion care.
- People's privacy, dignity and confidentiality were not respected. People's continence supplies were left in corridors or on their bedroom floors, without consideration for their privacy, dignity and confidentiality.
- Care staff worked in a task-centred way when supporting people. Tasks were rushed and care staff did not always consider people's privacy and dignity. For example, one person had said they were cold. A care worker supported the person to put on a top to keep them warm. This support was provided in the lounge, with the person's clothes left across the back of their armchair.
- Staff were at times unkind, dismissive and lacked compassion towards people. For example, we observed one person sat with their bedroom door open while their call bell was buzzing, care staff walked past the person's room and ignored them. Another person said, "They [care staff] say to me 'you do know there are 26 people and only 2 of us don't you?'"
- People experienced discomfort and distress as their requests for assistance from care staff were not answered in a timely way or reassurance provided. At times people were seen crying or making distressed sounds as they were in discomfort and wanted support. One person said, "They [care staff] get a bit fed up with me because I press my buzzer."

We found some evidence that people had been harmed. The provider failed to ensure people were treated with dignity and respect. This placed people at risk of harm. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People gave some positive feedback about staff but recognised practices at the home impacted on staff being able to work in caring ways. One person told us, "They are good but so very very busy and nights when the agency staff are on can be poor."

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

- People were not involved in their care and support in a way that made them feel they mattered.
- People's care and support was organised for staff convenience. For example, people were given meals in their bedrooms as this was easier for staff to manage. On day 2 of the inspection, one person ate their breakfast in their bedroom as staff had not time to support them with their personal care and they did not want to go to the dining room in their nightwear.

● People were not consulted with or given choices, including about the home environment. The registered manager had arranged for pictures of lakes to be placed on everyone's bedroom doors and on walls throughout the home. There was no recorded evidence people had been consulted about this. The registered manager told us, "They were ok with it."

We found no evidence that people had been harmed. The provider failed to provide person-centred care that considered and reflected people's preferences. This placed people at risk of harm. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following our feedback, a provider representative spoke with people to look at their preferences and changes needed at the home to accommodate these.

Inadequate

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant services were not planned or delivered in ways that met people's needs.

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

- People's care was not person-centred and had been developed to aid staff speed and efficiency rather than with consideration for people's preferences.
- People were encouraged to go to bed early as part of an established, institutionalised routine. Most people were in their bedrooms by 4pm, ate their tea at 4:30pm and then changing into their nightwear. People remained in their rooms until the following morning. One staff member was observed persuading a new person to go to bed early, when the person did not want to.
- Staff did not always have time to speak with people to provide them with stimulation or offer them choice. One person told us, "I like company sometimes. Staff don't have much time to chat to me."
- People's care and support was not always organised to meet their needs. For example, one person's care plan referred to them needing to be kept mentally active to improve their mood. Despite this, their care records gave no details of what activities they enjoyed and the person was routinely cared for in their room with limited opportunities for stimulation.

We found no evidence that people had been harmed. The provider failed to provide person-centred care that considered and reflected people's preferences. This placed people at risk of harm. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People were at risk of being socially isolated not having adequate stimulation to support their wellbeing. For example, one person tried to seek out staff to play scrabble with them. No attempt was made by staff to take the person's request seriously and facilitate this.
- Activities were planned in the home without any recorded evidence to show people had been consulted about this or what activities they would like to do.
- Activities were not always organised with people's safety in mind. People's walking aids were moved away from them as part of an armchair exercise activity. One person decided to leave during the activity and walked across the lounge without their walking aid, placing them at risk of falls and injury.

We found no evidence that people had been harmed. The provider failed to provide person-centred care, including activities that considered and reflected people's preferences. This placed people at risk of harm. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● People's communication needs were not always considered or met.
● The provider did not have an AIS policy or procedure in place to ensure AIS was followed. Following our feedback, the provide implemented this policy, although it was not adequate or specific to the home.
● Information about planned activities was not effectively communicated to people to enable them to participate in these. For example, a handwritten activity plan was attached to the activity room door. This was difficult to read and not accessible to everyone to see. People told us they were not aware of activities taking place in the home.
● People's sensory needs, including eyesight and hearing impairments were not met as part of their care and support. For example, no reasonable adjustments were made to enable one person with eyesight and hearing impairments to participate in armchair exercises.

We found no evidence that people had been harmed. The provider failed to provide person-centred care that was appropriate and met people's needs and reflected people's preferences. This placed people at risk of harm. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support
● People were not involved in planning their end of life care. This included one person who was receiving end of life care at the time of our inspection.
● Staff had not received training in end of life care to support them with providing specific care for this stage.
● The lack of staff knowledge of end of life care meant staff did not identify or highlight changes in a person's condition, which may indicate other health concerns or them entering a different end of life stage.

Improving care quality in response to complaints or concerns
● We were not assured people knew how to complain or felt able to do so. One person told us, "I wouldn't know who to complain to."
● Information about how to complain was displayed in the home in a written format. This was not accessible to everyone living at the service.
● People had limited opportunities to provide feedback on their care and raise any complaints or concerns.

Inadequate

Is the service well-led?

Our findings

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

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

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

At our last inspection the provider had failed to have effective systems in place to assess, monitor and improve the quality of the service and maintain complete records for people and staff. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 17.

● People were at risk of harm as effective governance systems and processes were not established to monitor quality and safety across the service.
● The provider's quality assurance system was ineffective and did not identify widespread issues we found during inspection or drive improvement. For example, medicines, legionella, staffing levels, safeguarding, recruitment shortfalls, staff training, activities, person-centred care and nutrition and hydration.
● We were not assured the registered manager had full oversight across the home. There was no recorded evidence that the registered manager was monitoring people's nutrition and hydration, medicines or water temperature checks.
● The registered manager was not always open or accepting of the issues found during the inspection. For example, they told us people chose to go to their bedrooms at 4pm. We observed staff encouraging this practice.
● Accurate and complete records were not always maintained of people's care. Full care records were not in place during the inspection for 3 people admitted to the service in June and July 2023.
● The service had been rated requires improvement or inadequate for the last 2 consecutive inspections and had failed to improve to provide a good level of care for people.

We found no evidence that people had been harmed. The provider failed to ensure systems and processes were in place to assess, monitor and improve the quality and safety of the service. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Staff reported low levels of satisfaction to us and described high levels of stress and work overload.

● Whilst some staff members told us they enjoyed caring for people, the provider's approach was not in-line with best practice guidance and person-centred care.

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 not assured duty of candour was always understood and followed by the registered manager and provider.
● Written evidence of duty of candour was limited. The registered manager showed 1 example of where they had written to a family following a person sustaining a fracture following a fall.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● There were limited opportunities for sharing information and obtaining the views of people who live at the home, their relatives and staff members.
● The registered manager told us they spoke with people informally during craft activities to listen to their wishes and views.
● Staff meetings were not always organised to enable all staff to attend these and contribute to discussions about the home. One night staff member said, "Staff meetings are put on at times that aren't great for [night] staff for example at 10am. We've asked if they could happen at the start of our shift or just before."

Working in partnership with others
● The service did not always work collaboratively or cooperatively with partner agencies, including the local GP surgery.
● Feedback from partner agencies working with the service was mixed. One health professional told us, "[Staff] do follow up on actions, try the suggestions but then may quickly say it does not work."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider failed to ensure the premises and equipment were secure and suitable for their intended use. (2)(b)(c)