Saxby Care Ltd

Saxby Lodge 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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Saxby Lodge Residential Care Home accommodates up to 19 older people including people who live with Dementia. There were 15 people living at the service at the time of our inspection. The premises are a converted domestic property situated in a residential area.

People's experience of using this service and what we found
People who lived at the service, and who were dependant on staff for their hydration needs, were at risk from dehydration and increased risk of urinary tract infections (UTI). This was because records of their fluid intake were incorrect and misleading. Some people were at risk of potential weight loss as their nutritional needs were not always being met.

Staff were not trained to meet the needs of people who had specific health and support requirements such as Parkinson's Disease or required support to eat. Some staff were unaware of people's underlying health conditions and associated risks. This meant there was a risk that staff could miss the signs that a person's health was deteriorating and the required action to take.

Information in people's care records and staff knowledge was not enough to ensure safe care. For example, where people had significant terminal health conditions their care plan's failed to provide any information to guide staff on the care or treatment they required.

Appropriate action was not always taken to mitigate risks to people. There was a failure to assess and mitigate known risks to people such as those associated with respiratory conditions, the risk of catheter induced infections, changes in blood sugar levels and required action for people with diabetes.

Our observations showed there were not enough staff deployed during the day to provide people with personalised care, meaningful occupation and to keep people safe. A relative told us "I am unhappy with the staffing levels and have commented as such to Saxby Lodge. Because I visit regularly, I recognise staff and am concerned since the new ownership longstanding staff have left. There have been, in the past six weeks, at least five new faces. They seem to be very short staffed at weekends and no sign of any managerial support."

Environmental risks were not always well managed. We observed some poor practice with environmental safety including a failure to safely control substances that are hazardous to health (COSHH), safe storage of medicines and infection prevention and control.

The service was visibly unclean in places and there was a very strong smell of urine in parts. One person told us it was like living in a urinal and visitors to the service described the small of urine to be overwhelming. This did not make for a pleasant and dignified environment in which to live. Relatives described the environment as shabby with equipment and furnishings that were worn and old. One relative said, "My first visit I was quite shocked to see how shabby and run down the interior of the home was and my first thought

was to get her out of there".

People told us they spent most of their time alone in their bedrooms. There was little opportunity for meaningful occupation and stimulation. People told us they did not use the main lounge as it was not very stimulating, one person said, "I get more company from my TV than I do in the lounge".

Care plans did not always reflect people's individual preferences for how they wished their care and support to be delivered. Care plans did not clearly identify which aspects of their care people could manage themselves or the type of support people required in order to promote independence.

There was a lack of leadership and oversight of the service. People, staff and relatives consistently told us how they had fed-back concerns and suggestions, but these had not been acted upon. A relative told us, "Saxby Lodge is no longer the home it was. Having given the new owners a reasonable period of time to settle in, and I know change is always difficult for staff, residents and relatives alike, I am considering seeking an alternative placement."

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible, the policies and systems in the service did not support this practice. People's liberty may have been deprived without the lawful safeguarding in place to protect their rights.

Some people shared their positive experiences of living at the service. One person told us how good it was to know that there were people around if needed, and that made them feel safe. Another told us staff were kind and a relative said, their loved one had recently moved in and they found the service to be ok, staff were friendly, and they would recommend it to others.

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

Rating at last inspection
This is the first inspection under a new provider since they were registered with CQC in February 2021. The last rating of the service under the previous provider was rated Good (published in 6 June 2019).

Why we inspected
The inspection was prompted in part due to concerns received about standards of care in relation to insufficient food, drink and insufficient staffing levels and competencies. A decision was made for us to inspect and examine those risks.

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.

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

We have identified breaches in relation to: risk management, medicines management, safe staffing levels,

staff training, ensuring adequate nutrition and hydration, maintenance and cleanliness of the premises, ensuring people received person centred care and support, treating people with dignity and respect, the need for consent ensuring, systems and processes are operated effectively to assess, monitor and improve the quality and safety of the service at this inspection.

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 request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit to review the improvement made. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service is 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 six 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, 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.	**Inadequate**
Is the service effective? The service was not effective.	**Inadequate**
Is the service caring? The service was not always caring.	**Requires Improvement**
Is the service responsive? The service was not always responsive.	**Requires Improvement**
Is the service well-led? The service was not well-led.	**Inadequate**

Saxby Lodge 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 Care Act 2014.

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

Inspection team
The inspection was undertaken by one inspector.

Service and service type
Saxby Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. 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.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service. The provider was not asked to complete a

provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

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

We reviewed a range of records. This included six people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at quality assurance, training records, staffing rotas and accident and incident records. We sought feedback from a further four relatives and six staff. We also sought urgent assurances from the provider relating to nutrition and hydration, staffing competencies and the management of the service. We shared concerns about aspects of the care with Local Authority commissioners

Inadequate

Is the service safe?

Our findings

This is the first inspection for this newly registered service. This key question has been rated Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong.

- Risks to people were not assessed and managed and there was a failure to learn from events to improve safety.
- Information in people's care records and staff knowledge was not enough to ensure safe care. Where people had health conditions such as diabetes, Parkinson's disease, dementia or cancer information was not available to ensure staff knew how to support the person safely and consistently.
- For example, where people had significant terminal health conditions their care plan's failed to provide any information to guide staff on the care or treatment they required. For people with diabetes there was an absence of any information within the care plans to ensure their diabetes was managed and monitored safely. This meant that people could not be assured of receiving safe care and there was an increased risk for potential harm to people.
- Appropriate action was not always taken to mitigate risks to people. There was a failure to assess and mitigate known risks to people such as those associated with respiratory conditions, the risk of catheter induced infections and changes in blood sugar levels and required action for people with diabetes. Records showed that several people had experienced urinary tract infections (UTI) however actions to mitigate a further occurrence were not recorded within their care records.
- Some staff were unaware of people's underlying health conditions and associated risks. This meant there was a risk that staff could miss the signs that a person's health was deteriorating and the required action to take.
- For example, advice from a district nurse regarding a person's skin integrity was not reflected in the person's care plan. This included advice for regular repositioning. We observed the person to spend the day in the lounge sitting in the same chair without regular reposition. There was no record of any repositioning for the person and staff were unable to confirm that this had happened. This meant the person was at increased risk of developing pressure sores.
- There was a lack of effective oversight and monitoring of head injuries. Accident and incidents records showed that where people had sustained a head injury there was no evidence that a period of enhanced monitoring had been implemented. This included a failure to follow direct advice from a medical practitioner to monitor a specific person following a head injury. Processes had not been implemented to increase observations and there was little guidance on signs and symptoms to look out for following the person's head injury. Consideration had not been given to the potential risk of head injuries being life threatening.
- Environmental risks were not well managed. We observed some poor practice with environmental safety including a failure to safely control substances that are hazardous to health (COSHH). The service supported people with dementia and people were able to mobilise independently around the building. We observed bottles of spray bleach in the manager's office and a cleaning cupboard next to the dining room containing COSHH products which had the door wedged open. The products were easily accessible and posed a risk to people if ingested or inhaled. The registered manager took immediate action to lock the cupboard.

However, five minutes later the door had been wedged open again and the cupboard unattended. There was a large carving knife easily accessible in the kitchen, a retractable barrier with 'No Access' signage restricting access to a fire exit and a pool of water on a toilet floor creating a slip hazard which staff said was caused by a long standing leak. The provider's quality monitoring systems and skills of staff had not been effective in identifying and mitigating these risks.

Systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was asked to take immediate action to address the serious risks to people's safety identified. Following the inspection, we were provided with written assurances from the provider of the action they had taken to address the immediate safety concerns.

Staffing and recruitment

● There were not enough suitable staff to meet people's needs and keep them safe.

● Prior to our inspection we had received information of concern about insufficient staffing levels. The provider did not have a system in place to assure themselves that there were sufficient staff to meet people's needs. The provider told us they had recently increased staffing levels to three care staff during the day following recent feedback from staff. At night there were two waking care staff on duty.

● Our observations showed there were not enough staff deployed during the day to provide people with personalised care, meaningful occupation and to keep people safe. We observed a failure to ensure enough staff to support people to eat and drink and people told us they had to wait for long periods of time to have their personal care needs met.

● Visitors to the service shared their experiences of staff who were rushed and did not have enough time to provide quality care and support to their loved ones. This included people being forgotten about whilst using the commode and staff leaving partway through washing and dressing a person to assist someone else. A relative told us "I am unhappy with the staffing levels and have commented as such to Saxby Lodge. Because I visit regularly, I recognise staff and am concerned since the new ownership longstanding staff have left. There have been in the past six weeks at least five new faces. They seem to be very short staffed at weekends and no sign of any managerial support"

● Care staff told us that as well as providing personal care they also administered medicines, prepared and served the evening meal and were expected to undertake some cleaning tasks. This meant when there were three staff on duty and people required two staff to provide personal care whilst staff were engaged in domestic tasks or 1-1 support the lounge was left unattended. Our observations showed that people spent long periods of time alone in their rooms without staff support or interaction.

● The registered manager told us there were occasions when the rota could not be covered and the number of staff on duty fell below what was required. People and visitors to the service were concerned about the recent high turnover of staff. Agency staff were not used, and staff told us the service relied on them working additional hours or taking on additional tasks to cover gaps in the rota. For example, when the cleaner was recently absent for ten days care staff had undertaken the cleaner's duties within their normal care hours. This took staff away from providing direct care and support.

There was a failure to ensure there were enough competent and skilled staff deployed to meet the needs of the people using the service. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● There were safe systems and processes for the recruitment of staff. The provider followed safe recruitment

processes to ensure people were suitable for their roles. This included undertaking appropriate checks with the Disclosure and Baring Service (DBS) and obtaining suitable references.

Using medicines safely

● There was a failure to ensure medicines were stored safely. National Institute of Health and Care Excellence (NICE) guidance requires medicines to be stored safely. This includes medicines being stored securely and at safe temperatures. Some medicines including antibiotic liquids need to be stored securely in fridges that can maintain a temperature of between 2-8 degrees. The service did not have a dedicated medicines fridge and we observed bottles of liquid antibiotics stored on a shelf of the fridge in the main kitchen along with items of open food. The medicine was not stored in a lockable container and the fridge was observed to be frequently accessed by all employed staff. The provider could not be assured medicines stored in the kitchen fridge were safe to use and kept secure.

● People had their own lockable medicines cabinets in their bedrooms. We observed unsecured prescribed medicines on top of a medicine cabinet. Staff told us this was because the medicine packaging was too big to fit into the cabinet. There were unopened prescribed eyedrops and inhalers for two people dated between April and June 2021 on a table in a room used for storage. Medicine audits were not undertaken and therefore processes were not in place to have identified the failure to store and record medicines appropriately and in line with best practice NICE guidance.

Medicines were not managed or stored safely in line with required guidance. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us they received appropriate support with their medicines. We observed staff were competent at recognising the signs and symptoms that could indicate a person was experiencing pain and how to address this appropriately with the person.

● Protocols were in place for people who required medicines to be administered 'as and when required' (PRN). Staff completed training to administer medicines and Medicine Administration Records (MARs) were completed in line with best practice guidance.

Preventing and controlling infection

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. The service was visibly unclean in places and there was a very strong smell of urine in parts. One person told us it was like living in a urinal. Floorings and furnishing did not make the service easy to sanitise. Bags of solid laundry were stored by the open access to the kitchen and staff were using the laundry as a cut through to the kitchen without consideration to changing their PPE and ensuing good hand hygiene. We have signposted the provider to resources to develop their approach.

● We were not assured that the provider was using PPE effectively and safely. We observed poor infection control practices of staff, including a used face covering discarded on the kitchen work top and staff not changing PPE between providing personal care and making drinks in the kitchen. We have signposted the provider to resources to develop their approach

● We were somewhat assured that the provider was making sure infection outbreaks can be effectively prevented or managed. There service had not had an outbreak of Covid 19. However, process designed to effectively manage an outbreak were not always in line with government guidance. For example, staff were required to walk through the service to get to the designated changing area in an unused bedroom. We have signposted the provider to resources to develop their approach.

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Systems and processes to safeguard people from the risk of abuse
● Systems and processes protected people from the risk of abuse. Safeguarding training was completed by new staff and there was a system to ensure staff 's knowledge was updated. Staff were clear about their responsibilities in relation to safeguarding and worked in line with the local authority safeguarding policy and procedures.
● People told us they felt safe and were supported to keep themselves and their belongings safe. One person said, "I feel safer here than I did at home and I think it gives my family peace of mind too". Another person told us it was good to know that there were people around if needed and that made them feel safe. People told us staff were kind and relatives said they were assured that their loved ones were safe from harm.

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.

This is the first inspection for this newly registered service. This key question has been Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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

● People who were dependant on staff for their hydration needs were at risk from dehydration and increased risk of urinary tract infections (UTI) as records of their fluid intake were incorrect and misleading. We observed that staff were inconsistent with how they recorded people's fluid intake and we identified significant discrepancies which overestimated the amount of fluids being recorded.

●The NHS recommend adults to have between 1600-1800mls of fluid a day. This is known as the recommended daily allowance (RDA). The fluid intake records of people who had a history of UTI or required support to drink showed people often consumed less than 1000mls of fluids a day. Processes were not in place to identify or act promptly when people failed to achieve their RDA.

● For example, a person had been admitted to hospital with kidney injury and urosepsis and signs of dehydration. For the 10 days prior to the person's hospital admission fluid intake records showed they averaged 600mls of fluid a day. During this 10 day period the met office issued an amber heat warning alert for West Sussex. This meant people are likely to experience some adverse health effects including dehydration. During this period of extreme heat there was no evidence that the person's fluid intake had been increased or monitored. Following this event medical professionals raised a safeguarding concern to the local authority about the care provided at Saxby Lodge.

● People were at risk of potential weight loss as their nutritional needs were not always being met. We observed two people at lunch time who required support to eat and drink. One person was alone in their bedroom for 40 minutes and was not provided with any support. The second person was in the lounge and was asleep for the duration of time their lunch had been placed in front of them. Both people's meals were taken away because it was assumed, they were not hungry. Consideration had not been given to the lack of support as the reason they had not eaten their meal.

● We viewed the Nutrition and hydration care plans of both people and records of their weight. One person had been admitted to the service six weeks prior to the inspection. Their care plan records they are very underweight and have been prescribed food supplements by a dietician. The person's weight was not being monitored on a regular basis and records showed one record of their weight since their admission. The second person's weight record showed they had lost 1.2 kg over the last month. They had recently been prescribed food supplements following concerns raised by a visiting health professional about the person's weight. Concerns about the person's weight were not reflected in their care plan and a MUST assessment had not been undertaken to determine the person's risk of malnutrition and the support required to mitigate this. This meant that staff did not have all the information they needed to provide effective care.

Failing to ensure people have adequate nutrition and hydration to sustain good health and reduce the risk

of dehydration and malnutrition is a breach of Regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As a result of our concerns about people's nutrition and hydration we raised concerns to the local authority for consideration under their safeguarding guidance. In response to us seeking urgent assurances about people's food and hydration needs, the provider told us they had taken immediate action. This included seeking further medical intervention regarding unplanned weight loss. They also increased fluids to support people's hydration and improved monitoring and oversight of food and fluid intake and recording.

Staff support: induction, training, skills and experience

● The provider did not have a robust induction programme for staff to prepare them for their role. There was no record of induction for new staff and the registered manager and provider were unable to confirm what induction they had undertaken. Processes were not in place to check that staff had the competencies, skills and experience required for the role. A staff member told us, "We have three new staff that have done care before but not with us. We used to do shadow shifts so they would work with us to see how the routine works but they have not done this".

● Staff were not trained to meet the needs of people who had specific health and support requirements such as Parkinson's disease or support to eat and drink, although training records showed that some staff had recently accessed training in dementia.

● For example, we asked staff how they supported a people to minimise the impact of Parkinson's Disease. One said they didn't really have to do anything differently and another told us they needed to be aware the person could be a bit shaky at times. There was a failure to consider the persons emotional wellbeing or the challenges they faced with aspects of daily living, health and fitness and maintaining aspects of their independence. This meant people could not be assured of receiving care specific to their needs to help them achieve the best quality of life.

The failure to ensure staff had the appropriate training and skills to ensure people's needs were met is a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider gave assurances that they would be addressing gaps in specific training needs such as hydration and nutrition and supporting people to eat and drink.

●The registered manager monitored people's training records. Due to the recent change in provider some staff training was not up to date. Gaps in people's essential training was being addressed by the provider and the registered manager had planned for some face to face training in the coming month.

● The Registered manager provided staff with formal supervision and an appraisal in May 2021. Staff report that the new registered manager is engaging with them and asking for their input and addressing their learning needs.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; 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 Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● Mental capacity assessments were not always undertaken for people's consent to care and treatment. Where people required a DoLS applications had not always been made. For example, where it had been identified during the referral process that people lacked capacity to make decisions about their care and accommodation DoLS applications had not been made. Therefore, people's liberty may have been deprived without the lawful safeguarding in place to protect their rights. Following our inspection, the local authority advised the provider to make DoLS referrals for two people and undertake a mental capacity assessment for a third person.

● Staff had undertaken MCA training but were unsure about how to apply the MCA framework when supporting people with decisions about their care. One person's care plan advised that staff may need to make best interests' decisions around their medicines and personal care although there was no evidence of a mental capacity assessment being undertaken to support this advice. This meant the person could not be assured that decisions made in their best interests were legally authorised under the MCA.

● Staff lacked knowledge and understanding of DoLS. Staff were unsure if anyone living at the service had a DoLS in place. Staff were unsure about how DoLS related to people living at the service other than having the front door locked. This meant that staff may not recognised when a persons liberty was being deprived without lawful consent.

People's consent to care, and treatment was not always gained lawfully and from the relevant person. This is a breach of Regulation 11 (Consent to care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's needs were assessed before they started to receive support from the service. The information gathered was not always robust enough to ensure people's needs could be met. People's protected characteristics under the Equality Act (2010), such as disability, ethnicity and religion were not always considered in a meaningful way during the assessment process. People's assessments had not been reviewed and updated when their needs changed. For example, following discharge from hospital for following falls and injuries.

● Staff told us people's needs were not always accurately reflected in the providers assessments process. We were informed by staff that upon admission to the service "we find that sometimes they should be nursing care not residential, we are not trained or paid as nursing care, we don't have equipment for nursing care".

● There were some assessments tools in place to assess risks to people such as Malnutrition Screening (MUST) and falls. However these were not used consistently and there was a failure to undertake these assessments for some people with known risks such as falls and malnutrition. People had personal evacuation plans (PEEPS) in place to aid safe evacuation in the event of an emergency.

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

●The environment was not adapted, decorated or maintained to support people's needs and promote their wellbeing.

●There was a strong melodious odour in some parts of the service, one person told us the smell had been present for several months. This did not make for a dignified and comfortable environment. A relative told us that they would not bring other relatives to visit as the smell of urine "can be overwhelming".

● The decoration, furniture and fittings in the service looked tired, and in some places in a poor state of

repair. Relatives described the environment as shabby with equipment and furnishings that were worn and old. Another relative told us "My first visit l was quite shocked to see how shabby and run down the interior of the home was and my first thought was to get her out of there". We discussed this with the provider, and they told us that they had plans to redecorate and refresh the service. We saw evidence that some bedroom carpets had recently been replaced. There was no formal plan of redecoration with timescales.

● The environment did not always support the wellbeing or needs of people who were living there as some people were living with dementia. The general environment did not reflect national good practice guidance for supporting people with dementia. This included the lack of orientation prompts to support to promote a positive stimulating environment in which to live and support independence.

● People told us the environment was not very stimulating. Most people were observed to spend their time alone in their bedrooms. People told us they did not use the main lounge as it was not very stimulating, one person said, "I get more company from my TV than I do in the lounge". We observed that the lounge upstairs was used as a storage facility for furniture including mattresses which prevented people from using it. People and their relatives told us there was a lack of facilities and staffing to enable people and their visitors to sit in the garden and staff told us the lack of call bell facilities in the conservatory meant that people were discouraged from using it.

The failure to ensure the premises are clean, properly maintained and suitable for the purpose for which it is being used is a breach of Regulation 15 (Premises and equipment) 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

● Staff liaised effectively with the local GP surgery and people received support from specialist health care professionals. Records showed that people had regular access to health care professionals, GPs and specialist nurses.

● Care records showed that people had access to routine and specialist health care appointments. Records were kept about health appointments people had attended and staff ensured that guidance provided by health care professionals was implemented. We reviewed one person's medical records and saw that staff had sought a medical investigation when they had become concerned about a change in the person's well-being.

Requires Improvement

Is the service caring?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- People and their relatives told us they did not always receive care and support in a dignified way. We were told about a person who had been given their first cup of tea in the morning whilst sitting on the commode. The person's relative described this as, "demeaning and unacceptable care."
- Relatives shared their feedback of their loved ones not being in control of their lives. One told us their loved one had no say over the time they were supported to bed. Staff told us this was due to staffing levels at night being reduced and they were expected to have as many people ready for bed before the night staff came on duty. We spoke to other people who told us they were told when to go to bed and when to get up in the morning rather than being given a choice. One person said, "we do as we are told because there is not enough staff and the ones we do have are so busy we try and make things easier for them".
- We were also provided with examples from people and their relatives where people's personal items such as shampoo and hairspray were borrowed for other people to use. We raised these issues with the provider who agreed to take appropriate actions.
- At lunch time there were three staff on duty. Two staff were providing 1-1 support with feeding and mealtime assistance. We observed the third member of care staff in the kitchen eating a meal prepared by the chef. During this time two people with identified support needs at mealtimes were left without support and neither person ate their meal before it was cleared away. We raised this issue with the provider and manager who told us they would take immediate action to address this.

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

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

- Systems and process were not in place to enable people to make decisions about their care. Records did not always contain enough personal details to enable staff to know how to support a person to express their views or make decisions and choices about the care they receive.
- People and their relatives told us prior to the new manager commencing they had not been involved in the planning and reviewing of their care. The new provider had implemented a new care planning system and the registered manager had begun to review people's care plans with an aim to making them more personalised, detailed and reflective of people's wishes. The system was not yet embedded, and we have identified this as an area of practice that needs to improve.
- We observed some positive interactions between some staff and people. Interaction mainly centred

around times when personal care was being provided. People told us staff were friendly and caring although they wished they had more time to spend with them.

● A relative told us "In the most part they are very good at caring for the guests and have worked together for a long time, which can only be a good thing" another told us their loved one had recently moved in and they found the service to be ok, staff were friendly and they would recommend it to others.

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Meeting people's communication needs

- People did not always receive personalised care that was responsive to their needs.
- People's needs were not always documented in a way that supported a person-centred approach. Care plans did not always reflect people's individual preferences for how they wished their care and support to be delivered. Care plans did not clearly identify which aspects of their care people could manage themselves or the type of support people required in order to promote independence.
- For example, where the outcome for a person was recorded as being as independent as possible with their personal care there was an absence of any guidance on the support the person required to achieve this. The persons care plan identified a need for one to two staff in all areas of personal care. There was a failure to provide any further information or guidance as to what type of support was required and what aspects the person could manage themselves.
- People did not always receive a person-centred approach to having their needs met. Assessments and risks assessments lacked important details, which impacted on the care plans developed for them and meant that staff had limited guidance to support consistent and safe care. For example, there was a lack of information on how to support people with dementia to reduce anxiety and stress. We observed that some people's medical conditions such as Chronic Obstructive Pulmonary Disease (COPD), dementia, cancer and Parkinson's Disease were recorded as strengths and there was a failure to provide staff guidance on how people wished to be supported with their medical conditions.
- The registered manager had begun to document personalised information about people's preferences, social backgrounds and things that were important to them. However, this information was not transferred into people's individual care plans or reflected in the day to day support that they received. Staff did not use this information to support people in a personalised way.
- For example, a person's care plan reflected that they were a social person who like to chat. The person told us they were lonely and their only opportunity for interaction was to sit by their bedroom door and watch staff as they passed by. The person told us staff were 'rushed of their feet' and did not have the time to arrange activities and opportunities for social engagement.

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- Peoples communication needs were identified; however, this information was not always reflected accurately or clearly within people's care records. For example, where it was identified that a person had difficulty communicating with people wearing a face covering there was no advice or guidance on how to

mitigate or overcome this.
● Another person's communication plan said the person had communication requirements due to their dementia and were at risk of isolation. It did not provide information as to the communication needs of the person and the measures to take to mitigate the risk of isolation.

Failing to ensure that people receive person centred care and treatment that is appropriate to their needs and reflects their personal preferences is a breach of Regulation 9 of the Health and Social Care act (Regulated Activities) regulations 2014.

● People told us that generally staff communicated with them verbally or by reading information out loud. A relative told us how their loved one found it difficult to understand some staff due to English not being their first language. We observed some positive interactions between people and staff.
● Staff said they were able to communicate with people effectively. We observed staff engaging with people effectively using verbal communication throughout the inspection.

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
●There was a lack of activities for people to support people's wellbeing and provide meaningful stimulation and occupation. Visitors and people told us that people often spent most of the day in their bedrooms sitting in the same chair. Some people told us that they would like more activities as sometimes they were lonely and board. For people living with dementia there was a lack of stimulating activities that gave purpose and pleasure. Staff were unaware of the positive benefits for people being engaged in suitable meaningful occupation to improve their quality of life.
● There was no regular programme of activities. During the inspection people were not provided with the opportunity to participate in any meaningful occupation.
● Occasionally the service arranged for outside entertainers to visit the service. Recently there had been an Elvis Presley impersonator who people had enjoyed signing along with. The registered manager told us that now restrictions imposed by the government due to the global pandemic had eased, they planned to arrange more entertainment and activities from community sources.

End of life care and support
● End of life care plans for people lacked details about people's wishes for support though their final stages of their lives. Staff told us that they did not feel adequately supported to discuss end of life care issues with people or their relatives.
● At the time of inspection, no one was receiving end of life care and support. Staff had recently received training in how to support people through the final stages of their lives.

Improving care quality in response to complaints or concerns
●Systems for addressing concerns and complaints were not consistent.
● We asked people if they knew how to make a complaint and people were unsure. One person told us that they would tell the registered manager, another said that they would tell their relative or staff if they were not happy about something. One person told us they did not feel listened to when they had raised a concern and despite raising the same issue on several occasions since April no action had been taken. We spoke to the registered manager and provider about this. They informed us they were aware of the person concerns although they had failed to document this. The concern related to an environment issue. The provider gave us assurances that this was in the process of being addressed and we passed this information on to the person who had raised the initial concerns.
● Relatives told us they have been raising concerns about the shabbiness' of the service, the "overwhelming

stench of urine" the and lack of stimulating activities for their loved ones. They have not felt listened to and have not seen any positive actions as a result of raising these concerns.

● We raised these concerns with the provider who said they had an improvement plan in place to address environmental issues. They told us there were plans for a full redecoration of the communal areas and they had begun to replace some floor coverings. The provider told us they would implement more effective communication with people and their families as a result of our findings.

Using the learning from complaints and concerns to review practice is an area that needs to improve.

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.

This is the first inspection for this newly registered service. This key question has been rated 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, 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, Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The service was not well-led. Governance arrangements were not effective in identifying shortfalls in the quality of the service.
- Systems and processes for quality monitoring had failed to identify significant shortfalls in practices related to the monitoring and recording of food and hydration. There was a lack of accurate and contemptuous personalised information in people's care records, poor infection control, redecoration and repair of the environment.
- Risk management processes had failed to identify and consider some risks to people's health and wellbeing. For example, where people were identified as requiring support to eat and drink including with cutting their food into small pieces consideration had not been given to assessing the person's risk of choking. This meant the provider could not be assured all reasonably practicable actions were considered and taken to mitigate risks to people.
- There was a lack of leadership and direction. The registered manager did not always have access to information that they required to effectively manage the service. For example, recruitment and training documents were not always available. This meant the registered manager could not always be assured of when new staff were starting and the training needs of staff.
- We were told that there were some shifts where there was no one in charge who had overall responsibility or accountability. This was because there was no deputy or senior care staff and when the registered manager was not on duty, no one was appointed in charge. One staff member told us the service was the most disorganised they had worked in.
- We received varied feedback about the leadership of the service. Staff told that the new registered manager was engaging with them and asked for their input. We received consistent feedback from staff, people and visitors about the providers failure to demonstrate their own knowledge and understanding of the care sector. A relative said, "I do not think it is managed positively - there appears very little on- hand manager interaction".
- CQC had not always been informed of incidents and events at the service which the registered manager and provider are required to notify us off. This is so we can be assured that events and incidents have been appropriately reported and managed.

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

characteristics, Continuous learning and improving care; Working in partnership with others

● The provider had not acted to develop a culture of respect and inclusion for everyone. People, staff and relatives shared examples with us where they had raised feedback or concerns to the provider regarding the environment and insufficient staffing levels but did not feel listened to. A staff member told us that the provider, "Tells us things are going to change but nothing changes". Another staff member said if the provider "was not happy about something, she doesn't speak to us properly it's like she is blaming us even if it's not". A staff member told us "I love my job, I love what I do, I just wish we could have a bit more input in things at the home".

● A relative shared with us their recent experience where they felt that communication had been poor with the management team. This was during a medical emergency of their loved one and described the interaction with the registered manager as "rather dismissive". Although they had a legal right to do so a relative told us that they were not kept informed by the registered manager of significant occurrences in their loved one's lives.

● Since taking ownership of the service it was not apparent that there was a plan of improvement for the service. A relative told us, "We didn't know it was recently purchased by new owners when mum first arrived. We would expect the new owners to be on the case with getting on and fixing the problems they saw when they purchased it straight away. It very much needed quite a lot of money spending on it e.g., (Call alarms, beds- mattresses, carpets, furniture and paint). Plus, there is an unbelievably strong smell". Several relatives told us that there had been little or no contact or communication with the new provider. One relative said, "I have only met the new owners once and that was only to discuss money ".

The provider had failed to act on feedback from people, staff and their relatives to continually evaluate and improve the service. The provider had failed to operate a robust quality assurance process to continually understand the quality of the service and ensure any shortfalls were addressed. The provider had not maintained accurate and complete records in relation to the service and people's care. This placed people at risk of harm. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Failing to ensure that people receive person centred care and treatment that is appropriate to their needs and reflects their personal preferences.

The enforcement action we took:

to impose positive conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect There was a failure to treat people with dignity and respect

The enforcement action we took:

Impose positive conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Peoples consent to care, and treatment was not always gained lawfully and form the relevant person.

The enforcement action we took:

Impose a condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. Medicines were not managed or stored safely in line with required guidance.

The enforcement action we took:

Impose positive conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Failing to ensure people have adequate nutrition and hydration to sustain good health and reduce the risk of dehydration and malnutrition

The enforcement action we took:

Impose a condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment There was a failure to ensure the premises are clean, properly maintained and suitable for the purpose for which it is being used

The enforcement action we took:

Impose positive conditions

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 act on feedback from people, staff and their relatives to continually evaluate and improve the service. The provider had failed to operate a robust quality assurance process to continually understand the quality of the service and ensure any shortfalls were addressed. The provider had not maintained accurate and complete records in relation to the service and people's care. This placed people at risk of harm

The enforcement action we took:

Impose positive conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was a failure to ensure there were enough competent and skilled staff deployed to meet the needs of the people using the service. The failure to ensure staff had the appropriate training and skills to ensure people's needs were

met

The enforcement action we took:

To impose positive conditions