Partnerships in Care Limited

Grafton Manor

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

About the service
Grafton Manor is a nursing home registered to provide accommodation and personal care to a maximum of 26 people. At the time of inspection there were 11 people with an acquired brain injury living at the service.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people and providers must have regard to it.

At the time of the inspection, the location did not care or support for anyone with a learning disability or an autistic person. However, we assessed the care provision under Right Support, Right Care, Right Culture, as it is registered as a specialist service for this population group.

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

Right support:
People were at risk of harm as the system to manage people's risks was ineffective. Staff did not have information for people's known risks such as skin pressure damage, falls, nutrition, moving and handling, swallowing difficulties, health conditions and people experiencing distress. This placed people at risk of unsafe care.

The provider failed to ensure enough staff were deployed to meet people's needs and people were not supported by a consistent staff team. Staff had not had all required training to meet people's needs, for example training to meet people's health care needs. High numbers of agency care and nursing staff were deployed, they had not received a suitable induction to the home. Staff were recruited safely.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

There were elements of environmental safety that needed to be addressed to ensure that the environment people lived in was safe. Risks posed by the environment had not been identified and as a result had not been resolved. Where risks had been identified insufficient action had been taken to mitigate these risks. Infection prevention and control measures were not consistently followed, some areas of the home were visibly dirty.

People's communication needs were recorded, and staff understood people's preferred communication.

There was some evidence that people had been involved in making decisions about their care. Where people were able, they contributed to regular discussions about their care.

The provider employed specialised services internally, this included staff from different disciplines such as occupational therapy and psychology. A plan of activities was in place and we saw people enjoying activities with therapy staff during the inspection.

Right Care:
Systems and processes were not established or operated effectively to ensure incidents of suspected abuse were reported to the appropriate authority.

People were at potential risk of harm from inappropriate physical interventions. Appropriate assessments had not been completed to ensure physical intervention was in people's best interest and not all incidents were recorded or reported. Agency staff were working in the home and had not received appropriate training in physical intervention.

We found that medicines were not always safely managed and that medicines records were not completed accurately.

Risks associated with eating and drinking were not always effectively managed as people did not always receive a diet appropriate to their health needs.

The provider failed to identify or manage risks posed by people's health conditions. People living with insulin dependent diabetes did not have care plans that reflected their current needs or inform staff how to mitigate known risks associated with the person's diabetes. Staff did not always monitor people's clinical signs as instructed in their care plans.

Right Culture:
There was a lack of effective monitoring in place and this had resulted in poor outcomes for people using the service. Ineffective quality monitoring systems had failed to pick up and address the failings we identified during our inspection. There was a lack of clinical oversight and leadership within the home.

People's personal preferences in relation to their care were not always considered. People did not feel listened to by the provider, as they had raised concerns about the service, but no action had been taken.

Staff did not feel supported or appreciated and were unsure about who was overseeing the management of the service.

The provider was open and transparent and developed an action plan to mitigate concerns found on inspection.

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

Rating at last inspection
The last rating for this service was Good (Published 17 August 2021)

Why we inspected
The inspection was prompted in part due to concerns received about staffing levels and safeguarding concerns. 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.
The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

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

Enforcement and Recommendations
We have identified breaches in relation to staffing, safe care and treatment, safeguarding, consent to care, and governance and leadership at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
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 on their 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 always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well led.

Details are in our well led findings below

Inadequate

Grafton Manor

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was carried out by 2 inspectors.

Service and service type
Grafton Manor is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Grafton Manor is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a manager registered with CQC, however they were no longer in post.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 24 November 2022 and ended on 15 December 2022. We visited the location on 24 November, 28 November and the 01 December.

What we did before the inspection
We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used all this information to plan our inspection.

During the inspection
People found it difficult to communicate with us about their experiences of support due to their complex support needs. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with 1 person and 5 relatives of people who used the service about their experience of the care provided. We spoke with 14 members of staff including the interim manager, area manager, administrative staff, nurses, care assistants, therapy staff, maintenance staff and kitchen staff.

We reviewed a range of records. This included 3 people's care records and multiple medication records. We looked at 6 staff files in relation to recruitment and multiple agency staff profiles. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to receive information relating to incidents, quality assurance and management of medical conditions. We sought clarification on staffing, staff training and competencies.

Inadequate

Is the service safe?

Our findings

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

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

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

- People were at potential risk of harm from inappropriate physical interventions.
- Appropriate assessments had not been completed to ensure physical intervention was in people's best interest and not all incidents were recorded or reported.
- Staff told us they regularly restricted one person's movement to enable their personal care to be provided. There was no record the person's ability to consent to personal care had been assessed and no care plan or risk assessment was in place to guide staff on how to physically intervene safely.
- Not all incidents of physical interventions or incidents where people were in distress had been recorded as an incident or reviewed and analysed. This meant the provider was unable to reflect and learn on past incidents or identify patterns and trends that were occurring.
- When staff recorded a physical intervention had been used, records did not contain type or duration of physical intervention used or the full names of staff involved. This meant there was no evidence of whether or not the techniques used were appropriate or safe.
- Staff had not followed the providers policies and procedures when managing physical interventions. Debriefs had not been completed with people or staff following incidents when a physical intervention was used. A debrief should be completed after every incident of physical intervention to help people and staff to identify what led to the incident and what could have been done differently, to also determine whether alternatives, including less restrictive interventions, could be used. This put people at risk of inappropriate or unsafe physical interventions.
- Systems and processes were not established or operated effectively to ensure incidents of suspected abuse were reported to the appropriate authority. A review of people's care records showed several incidents where people were either harmed or at risk of harm that had not been referred to the appropriate authority for further assessment.

The provider failed to ensure that people were protected from abuse and improper treatment. This was a breach of Regulation 13 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- People were at risk of harm as the system to manage people's risks was ineffective.
- Staff did not have information for people's known risks such as pressure ulcers, falls, nutrition, moving and handling, swallowing difficulties, health conditions and people experiencing distress. This placed people at risk of unsafe care.
- The provider failed to identify or manage risks posed by people's health conditions. People living with insulin dependent diabetes did not have care plans that reflected their current needs or inform staff how to

mitigate known risks associated with the person's diabetes. Staff did not always monitor people's blood glucose or ketones as instructed in the care plans, this meant 2 people experienced prolonged periods of high blood glucose which placed them at increased risk of serious medical conditions. (Ketones are chemicals the body produces when it breaks down fat for energy. If too many ketones accumulate in the body, they can become toxic).

● Staff did not always recognise or record people's symptoms which could indicate deteriorating health. There was no consistent clinical oversight of people's medical conditions to identify changes in their health. People living with diabetes and epilepsy were at increased risk of undetected ill-health.

● Some people living at the service received their nutrition via a percutaneous endoscopic gastrostomy (PEG). One person did not have a clear plan of care or records to demonstrate the person's stoma site was regularly assessed and action taken to prevent complications such as infection, pain or displacement of the tube. (A PEG is a tube that is passed into a person's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate.)

● Environmental risks such as water safety, fire safety and falls from height had not consistently been monitored or managed to mitigate risk.

Using medicines safely;

● People living with diabetes did not always receive their medicines in a safe or timely manner. Staff failed to give the correct dose of prescribed insulin or consistently record when they administered people's prescribed insulin. This put people at risk of complications and ill health due to blood glucose levels that were too low or too high.

● When people were prescribed medicine on an 'as required' (PRN) basis, staff did not record the reason and effectiveness of the medicine. Staff did not always have access to the protocols to inform them when 'as required' medicines could be administered. This meant people may not receive their medicines as required.

● One person received their medicines covertly, however, staff administering these medicines did not have evidence that all the safeguarding measures such as a best interest meeting, GP and pharmacy advice on how to administer these medicines safely.

● Audits had failed to identify that prescriptions for diabetes sensors had not been recorded on the medicine administration record (MAR) charts correctly. The sensors required replacing every fortnight; the MAR charts stated the sensors were applied topically four times a day. (A diabetes sensor is worn to monitor blood glucose levels for people living with diabetes.)

● Medicines audits also failed to identify there was no 'as required' prescription for insulin in the event of high blood ketone levels. This is necessary to ensure staff are able to administer insulin to prevent a potentially rapid deterioration in health.

The provider failed to ensure correct procedures to monitor and mitigate people's risks were implemented, and failed to ensure medicines were administered safely. This was a breach of regulation 12 (1) of The Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Staffing and recruitment

● The provider failed to ensure enough staff were deployed to meet people's needs.

● The provider had not assessed the number of staff required based on people's needs. The staffing assessment tool was based solely on the numbers of people receiving care. It did not consider the requirements of 2 people who required 1:1 support or the separate areas in the service where some people required their care to be provided.

● Seven of the 8 care and nursing staff we spoke with told us low numbers of staff deployed, and high use of agency staff affected their ability to meet people's needs. One member of staff said, 'Definitely not [enough staff], numbers were cut by [staff] and it's been a struggle ever since.' A member of bank staff told us they

had stopped working shifts in the home due to inconsistencies in staffing and there not being enough staff deployed.
● Care records showed there were delays in people's assessed needs being met due to staff not being available. For example, there were delays to personal care being provided following incontinence. This put people at risk of infection and damage to their skin.
● Records showed on one occasion there were insufficient staff to respond to an emergency. Staff attending the incident used their emergency alarm to gain assistance from other staff but no staff attended to support.
● Staffing planners over 3 days of the inspection showed one person did not receive their 1:1 support for all the hours directed in their care plan. The support was in place to mitigate risks posed by the person to other people living at the service. The lack of 1:1 at times it had been identified as necessary placed people at risk of harm.

The provider failed to ensure there were enough staff deployed to meet people's needs. This placed people at risk of harm. This was a breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were recruited safely. Staff files viewed on inspection, contained evidence of references being received and criminal record checks being completed before staff started to work at the service.

Preventing and controlling infection
● We were not fully assured that the provider was promoting safety through the layout and hygiene practices of the premises. Some areas of the home, such as the kitchen were visibly dirty. We found gaps in recording of cleaning and the provider confirmed cleaning staff did not work weekends.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● The provider followed government COVID-19 guidance on care home visiting. Visitors were welcomed at any time and were provided with appropriate PPE.

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.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- The provider failed to ensure all people's needs had been assessed. Care plans and risk assessments did not contain updated, factual information.
- The provider did not use evidence-based tools to identify and meet people's needs. For example, tools to identify people's risk of skin pressure damage or malnutrition were not in place. This put people at risk of malnutrition and skin pressure damage.
- People living with long-term conditions did not have their conditions assessed, monitored or managed in line with best practice guidance. The provider failed to have systems in place to implement best practice in the care of diabetes and epilepsy. This placed people at risk of unsafe care.
- People who became distressed while receiving care did not have appropriate assessments or care plans to guide staff in the best way to support them. Best practice guidance was not followed as incidents involving behaviours linked to people's health conditions were not fully recorded or reported.

Supporting people to eat and drink enough to maintain a balanced diet
- Risks associated with eating and drinking were not always effectively managed.
- One person's nutritional care plan stated they required a high protein diet, however, their care records showed staff regularly provided them with a high carbohydrate diet. This had a direct effect on their health due to their diabetes.
- People were supported to make choices for meals and drinks and to ensure they had enough to eat and drink.

The provider failed to ensure people's needs were assessed, monitored or managed. This was a breach of regulation 12 (1) of The Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Staff support: induction, training, skills and experience
- The provider failed to ensure suitably trained and supervised staff were deployed to meet people's needs.
- A high number of agency care and nursing staff were deployed at Grafton Manor. None of the agency staff had received appropriate training in restrictive physical intervention. Staff told us and records showed some people had their movement restricted while their care was provided. This put people at risk of injury from having their movement unsafely restricted.
- A review of agency nurse inductions showed none had received the required induction into the home. Areas such as medicines competency, safeguarding and health and safety had not been completed. The provider could not be assured agency nurses were competent to meet people's nursing needs.

● Staff had not received training to meet the needs of people with health conditions such as diabetes and epilepsy. We found the support people were receiving for their diabetes was unsafe.
● Since 1 July 2022, health and social care providers registered with CQC must ensure that their staff receive training on learning disabilities and autism appropriate to their role. Grafton Manor has a service user band of learning disability and autism; however, no training had been provided to nursing and care staff in learning disabilities and autism.
● Staff told us they did not receive regular supervisions and did not feel supported in their roles.

The provider failed to ensure staff were competent to provide safe and effective care. This was a breach of regulation 18 (1) 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).

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 requirements of the Mental Capacity Act (MCA) 2005 and the need to consider the least restrictive options when developing people's plans of care had not been implemented.
● Mental capacity assessments and best interest decisions had not been completed when people required physical interventions from staff to meet their needs.
● Where mental capacity assessments showed people lacked capacity to consent to their care, there was no evidence the care being provided was the least restrictive option or in their best interest.
● Although some mental capacity assessments for other areas of people's care appeared to have been recently reviewed and contained recent review dates, information contained within them was old. For example, the mental capacity assessment for one person who had been at Grafton Manor for a number of years referred to them recently transferring to Grafton Manor.

People's consent to care and restrictions had not been assessed. This was a breach of regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The provider had assessed people to see if they were at risk of being deprived of their liberty and had made DoLS applications for a number of people.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● The provider monitored people's health, care and support needs but did not consistently act on issues

identified. One person's relative and staff told us that poor communication from the provider had resulted in lengthy delays to one person receiving an appropriate wheelchair.

● Care plans contained referrals to other medical professionals and recommendations were received however staff had not followed the recommendations. For example, guidance provided by a specialist diabetic nurse.

● The provider employed specialised services internally such as an occupational therapist, psychologist. A regular meeting was held to discuss people's needs; however, this had not resulted in people receiving effective care.

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

● Grafton Manor is a grade II listed building which has been adapted to provide accommodation in several buildings. At the time of the inspection one area of the building was closed and people's care was provided in the main building, with one person being supported on a one to one basis in an annexe.

● Communal areas had been decorated in a homely manner and people could personalise their bedrooms. A refurbishment plan was ongoing at the service.

● The service had extensive grounds that people could access with staff support. Work was ongoing to make outside areas more accessible to people.

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.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- People were not always treated with dignity and respect and their independence was not promoted.
- People's experience of care was affected by the insufficient staffing levels in the home. The provider had not taken account of people's views, needs and preferences when allocating staffing levels.
- People told us there was a lack of support for people to maintain their independence. One person told us they told us they spent a lot of time sitting in their room as there was nothing to do. They said their planned cooking sessions did not happen as staff were too busy. Another person's relative told us their physiotherapy had not occurred as planned due to a lack of physiotherapy staff. A part time locum physiotherapist was in post at the time of inspection.
- People's relatives told us they were concerned their loved one appeared unkempt when they visited. One person's relative said they now supported the person with personal grooming when they visited as they could not rely on staff to provide the support.
- Records showed people had been left for prolonged periods before personal care was provided following incontinence.

The provider failed to ensure people were provided with appropriate person-centred care that met their preferences. This was a breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People and relatives were positive about the kindness of individual staff.

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

- We found some evidence that people had been involved in making decisions about their care. Where people were able, they contributed to regular discussions about their care.
- Some people's care plans included information on the way they would like their support to be provided and the activities they would like to take part in. However, staffing deployment reduced the ability of the service to respect the decisions people had made. For example, decisions about activities people wanted to do.

Requires Improvement

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. 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; 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 did not always receive personalised care that met their preferences.
- We observed during the inspection the mix of staff deployed did not enable people to receive personal care from the sex of care staff identified as their preference in their care plan. Rotas showed preferences had not been met on multiple occasions.
- People's care plans were not always updated to reflect people's current needs. One person's care plan referred to them spending their days in an area separated from the main building as they benefitted from a less stimulating environment. At the time of inspection, we saw the person's assessed needs were not being met as they spent the day in the main building, due to the quieter area being closed to people. There were no strategies or guidance for staff on how they were to manage this person's distress whilst these activities were not available.
- The provider did not always support people to follow their interests or encourage them to take part in social activities relevant to their interests.
- One person's plan of care included regular visits to their family. However, the person, their relative and staff told us visits were not carried out as planned as there were not always appropriate staff available to accommodate their needs. Cancelling the visits had caused distress to the person and their family.
- One person enjoyed regular shopping trips. However, we were told during the inspection their shopping had been cancelled at the last minute as there were insufficient staff to support them.

The provider failed to ensure people were provided with appropriate person-centred care that met their preferences. This was a breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Communal activities were planned daily and we saw people taking part in a sing-along and bingo during the inspection.

Improving care quality in response to complaints or concerns

- Complaints were not dealt with in an open, transparent, timely and objective way. The provider had a complaints policy in place and people knew how to raise complaints. However, complaints that had been raised had not always been responded to in line with the provider's policy.
- People's relatives told us where they had raised concerns these were not adequately addressed, and the incidents of concern continued to happen.

End of life care and support

● Staff had not received training in end of life care.

● People had not developed their end of life care plans to record their wishes and preferences. The provider told us people's needs were individually assessed and an end of life care plan would be completed for anyone identified as approaching the end of their life.

● There was no one receiving end of life care at the time of our inspection.

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.

● One person received visits three times a week from someone who shared their language and culture. Staff took this opportunity to communicate with the person to better understand their needs and enable them to ask questions.

● People's care plans contained information about their communication needs.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question good. At this inspection the service 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; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider failed to have systems and processes in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. This put people at risk of harm.
- People living with diabetes were placed at serious risk of ill health because there was no clinical oversight of their care. Systems to assess, monitor and review diabetes care plans and records were ineffective.
- The system to ensure safe management of medicines was ineffective, as the provider failed to identify that required medicine protocols were not in place to ensure as required medicines were safely administered.
- The provider failed to have systems to monitor the content of risk assessments and care plans. Staff did not have clear guidance from care plans and risk assessments. This meant staff did not have clear guidance on how to support service users safely. This put service users at risk of harm.
- The provider failed to ensure there was consistent managerial oversight of processes to ensure compliance with the MCA. Where people had restrictions placed upon their freedom of movement there was no assurance their care was being provided in the least restrictive way and in their best interest.
- The provider failed to implement an appropriate system to monitor, evaluate and ensure people's needs were met by enough staff with appropriate knowledge and skills to meet their needs.
- Audits were not effective in driving service improvement. During the inspection records relating to environmental safety showed outstanding actions had not been completed from previous internal and external risk assessments. For example, the external legionella audit completed in 2019 identified issues that required action. The latest external legionella audit dated 4 October 2022, identified the required actions had not been completed.
- Systems and processes were not effective in ensuring people's complaints were appropriately managed.

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

- The provider failed to notify the appropriate authorities of events and incidents which impacted people. Records showed there had been a delay in reporting a number of safeguarding incidents to the appropriate authority and CQC.
- The lack and delay of investigations following incidents, poor communication, delay in reporting of notifiable incidents and safeguarding concerns indicated the provider was not fully aware of their responsibilities under the duty of candour.

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

● People were invited to take part in community meetings to contribute to the running of the home. However, these did not always take place weekly as scheduled, minutes were only available for five meetings between August 2022 and the inspection; no meetings appeared to have taken place in October. Where concerns or issues were raised in the community meetings there was no follow up action recorded. For example, people raised concerns about noise levels in the home at night twice in August but there was no record in the minutes of action taken.

● Some people's relatives told us communication from the provider was poor and they had difficulty gaining feedback about their loved one's wellbeing. One person's relative told us they were concerned by the number of management changes. They also said they used to receive regular reports on their family member's progress, but these had stopped around 6 months ago with no explanation.

● Staff told us they were not asked to contribute to the running of the home. They had not been asked to attend staff meetings for a long time and were unsure who was managing the home at the time of inspection.

● The provider was aware of concerns in the service but action to rectify concerns were ineffective as concerns were identified in multiple areas of the service during this inspection.

The provider failed to ensure the quality, safety and leadership of the service. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The provider was transparent and open during the inspection process. Concerns identified during the inspection were responded to promptly and an action plan put in place to address all concerns identified.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure people were provided with appropriate person-centred care that met their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure people's consent to care and restrictions had been assessed.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure correct procedures to mitigate risks to people were implemented and followed, and failed to ensure that medicines were administered safely.

The enforcement action we took:

Imposed conditions on the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure that people were protected from abuse and improper treatment.

The enforcement action we took:

Imposed conditions on the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure the quality, safety and leadership of the service.

The enforcement action we took:

Imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure there were enough suitably trained staff deployed to meet people's needs.

The enforcement action we took:

Imposed conditions on the provider's registration