Ashley Grange Nursing Home Limited

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Inspection report

Lode Hill
Downton
Salisbury
Wiltshire
SP5 3PP

Tel: 01725512811
Website: www.ashleygrange.co.uk

Date of inspection visit:
13 July 2022
15 July 2022

Date of publication:
28 November 2022

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
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
Ashley Grange Nursing Home is a care home providing personal and nursing care for up to 55 people. People are accommodated in one building, over two floors. The service had a contract with the local authority to support local hospitals with an early discharge programme. People were transferred to the service for a programme of rehabilitation prior to being discharged home or to other long-term care. 15 beds were allocated to this initiative. At the time of the inspection there were 38 people using the service.

People's experience of using this service and what we found
People, relatives and staff consistently told us staffing levels were not sufficient to meet people's needs. The provider told us they used a dependency tool to calculate staffing numbers, which was aligned to dependency needs. While this showed sufficient staff were deployed, this was not our experience and the feedback received during the inspection. Risk assessments had been completed but had not always identified risks to people and plans did not always show how staff managed risks. There was a risk of cross contamination because some equipment and furnishings needed repair or replacement and were difficult to keep clean. Staff understood their responsibilities to protect people from harm and abuse. Safe recruitment practices were in place. Systems were in place for people to receive their medicines in a safe way.

People were not always supported to have enough to eat and drink. 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 was evidence of collaborative working and communication with other professionals to help meet people's needs.

People spoke highly of the staff. Staff spoke with compassion about the people they supported. People's rights to privacy, dignity and independence were not always promoted. People's preference for male or female staff for support with personal care had not always been sought.

People did not always receive personalised care which met their needs, and care planning was not always effective. Records did not always show that care and support was provided in line with care plan guidance. People gave mixed feedback in relation to activity provision. There were opportunities for people, relatives and staff to give their views about the service.

The quality assurance systems in place were not effective because although areas for improvement had been identified, and action plans written, they had not been implemented. Staff consistently told us they did not feel valued or recognised by the provider.

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

Rating at last inspection
At the last comprehensive inspection, the rating for this service was Good (published 16/07/2019).

Why we inspected
The inspection was prompted in part due to concerns received about people's support. A decision was made for us to inspect and examine those risks.

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

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. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvement. Please see the Safe, Effective, Caring, Responsive and Well-led sections of this full report.

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

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

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We have identified breaches in relation to staffing, safe care and treatment, meeting nutritional and hydration needs, need for consent, person centred care and good governance.

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 from 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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 6 months to check for significant improvements.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Ashley Grange Nursing Home

Detailed findings

Background to this inspection

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

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

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

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

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a newly registered register manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. 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 judgements in this report. We used all of this information to plan our inspection.

During the inspection
During the inspection, we spoke to 24 people, six relatives and nine members of staff including the manager, senior managers, nursing and care staff, catering and housekeeping staff. We reviewed 12 care plans, and multiple medicine administration records. We toured the environment and considered documentation related to the management of the home. This included accidents and incidents, staff recruitment and training, complaints and quality auditing.

After the inspection
We continued to look at some records such as staff training. We gained feedback about the service from one health and social care professionals, currently involved with the home.

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.

Staffing and recruitment

- There were not enough staff to support people safely.
- People did not always feel safe at the home.
- Three people referred to unsettling events where people had come into their room at night. This had made them feel very anxious and unsafe, particularly as staff were not readily available to help. Other people were concerned at the time it took staff to answer their call bell. One person said, "They don't answer the bell, they don't answer the phone either. Sometimes I've tried to phone reception because nobody was answering [the call bell] but couldn't get through to anybody."
- A high level of call bells were sounding throughout the inspection. On three occasions, the inspection team were required to alert staff to people who needed assistance. This was because their call bells were not being answered. Three of the call bells were taking up to 20 minutes to be answered. This did not assure people's safety.
- A delay in answering call bells had been identified in a recent audit and there was an associated action plan in place. The registered manager confirmed a new call bell system was in the process of being installed. They said this would enable better monitoring.
- On the first day of the inspection, staff told us and records showed, there were three people who did not receive their personal care until the afternoon. Staff told us this was because they [staff] did not have time. Senior managers however told us they had investigated this, and it was each person's choice to be assisted later. This conflicted with what staff had said.
- The lounge and dining room were often left unsupervised. This meant staff were not available to assist people where needed. For example, one person was in the lounge, and tried to get up from their chair which was reclined. They looked unsteady and at risk of falling, so a member of the inspection team called staff to assist.
- There was a high reliance on agency staff. On the first day of the inspection, on the first floor, one permanent care staff member was working with two agency care staff. Senior managers told us the same agency staff were used to ensure consistency, but staff told us this was not always the case. Staff told us agency staff caused additional pressure and inconsistency, as they were not always aware of people's needs and preferences.
- A staff engagement survey had been undertaken with the heading, 'If you wouldn't move a relative into this Home, why not?' Many of the responses identified a shortage of staff. The reasons for staff leaving had also been monitored, with staffing being a key factor.
- People and their relatives told us there were not enough staff. One person told us, "I rang the bell for my pad to be changed. Three hours later nobody had been and I was ringing it again. The [permanent] staff are

absolute stars, but they can't do everything. It's all about the physical care, nobody has time for me as a person. I use [personal care] as the only chance to interact." Another person said, "I get help with washing and dressing, but I have to wait a long time. Everything here takes a long time. There aren't enough staff, they're too busy. They don't have time to chat." A relative told us, "The staff are all excellent, but there aren't enough of them, especially at weekends."

● Staff consistently told us they worried about staffing levels. Comments included, "I wouldn't recommend it here; not as it stands at the moment. There aren't enough staff. That's why I stay though, because who else have [people] got?" Another member of staff said, "I do feel it's unsafe at times because of the needs of people. We need more staff to make sure people have enough to eat and drink. If we don't have time to sit with people, it's not safe."

Failing to ensure there were sufficient skilled and experienced staff on duty was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager and senior managers told us a dependency tool was used. This helped them determine the numbers of staff required on each shift, which was aligned to dependency needs. They said that some staff roles which were not required, or cost effective had been removed as part of a restructure.

● Staff personnel files demonstrated a formal recruitment process was followed. This included checks of the applicant's identity, their right to work in the UK, past work performance, and if they were suitable to work with vulnerable people.

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

● Risks to people's safety were not always identified, or acted upon.

● One person was in bed with bedrails in situ, but their call bell was on the floor out of reach. They said they would bang the table with a hairbrush if they needed assistance, yet this was often unsuccessful. The person told us there was no point using their call bell, as staff would not respond. We activated the call bell, but no staff attended. This was because the call bell did not work. A senior manager replaced the call bell, but it worked intermittently. We asked the manager to monitor the call bell system to ensure the safety of people until the new call bell system was installed

● At least one person had a pressure sore. A care plan had not been put in place when the sore first developed. This did not ensure the person received support with their repositioning, or any necessary treatment required. Two days later, the sore had deteriorated to a grade 2 pressure sore.

● Some staff told us they were concerned that people were experiencing skin damage because their positions were not being changed as often as they should be. Comments included, "Maybe [people have wounds] because people don't get turned enough. That could be down to staffing levels" and, "We have a high number of pressure wounds. I think it's because we don't have enough of our own staff, although we do have some regulars [agency]. Although it's on the [recording system] that staff have changed people's positions, I'm not always convinced it actually happens."

● Care plans did not always give information about people's health care needs. For example, staff had documented one person's diabetes was uncontrolled. However, there was no information to inform staff of the signs and symptoms of high or low blood sugar or the actions they needed to take in these instances.

● Another person had a urinary catheter in situ. The plan for this person detailed how staff should maintain the catheter, how to empty it and how to keep it clean, including the signs and symptoms of an infection. Staff had also documented they needed to educate the person to maintain an adequate level of fluid intake within a 24-hour period. However, there was no definition of what 'adequate level of fluid intake' meant. Additionally, the fluid monitoring records showed the person's fluid intake was consistently poor. There was no guidance for staff about what they should do about this.

● People were at risk of dehydration. The electronic fluid recording system in use identified when a poor

fluid intake was documented. However, despite the system alerting staff, no further action appeared to take place. One member of staff told us two people were on "fluid watch". There was a red flag at the front of their care notes, which highlighted their fluid intake in the last 24 hours was deemed inadequate. However, despite being on fluid watch, monitoring records showed only 210 mls had been offered and 140mls drunk. No amounts were documented for the second person.

● People were at risk of choking due to staff not always knowing when they needed to supervise people when eating and drinking. One person told us they did not drink much as it made them cough. Their care plan identified they were at risk of choking, so required a textured diet and supervision when eating. An agency member of staff delivered the person's lunch to them but did not stay with them whilst they ate. A member of the inspection team asked a permanent member of staff about this. They said this should not have happened and asked the staff member to return and support the person with their meal. Another person had been assessed as a high risk of malnutrition, but they had not been referred to a specialised health care professional, such as a dietician. This was not in line with best practice.

● On the first day of the inspection, a member of the kitchen staff, delivered a tray of desserts for those people in their rooms. The staff member informed an agency staff member that two of the desserts were for people who had swallowing difficulties. The desserts were not covered or labelled. Another member of staff took some desserts from the tray, unaware of the differences. A member of the inspection team intervened in order to ensure the staff member knew the desserts were for specific people.

● Some people had been assessed as being at risk of falls. However, there was limited information for staff about how to reduce these risks. For example, guidance in one person's care plan was, "Keep room free of hazards and clutter, requires good lighting and remind [the person] to use frame."

Failing to ensure the risks to people's safety were identified and acted upon was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● A new call bell system was in the process of being installed and whilst the old system remained in operation, there were new units on the wall, which had not been connected. This impacted on people's safety. The provider was aware of this issue and had taken action to address it.

● Guidance was in place to help staff support people with their mobility. For example, care plans identified how to support a person to move with the hoist.

● Some people were at greater risk of harm if they fell because of the medicines they were prescribed. In these instances, care plans informed staff to inform the GP if the person hit their head. Post falls monitoring took place.

Preventing and controlling infection

● Systems in place to prevent and control infection were not always effective.

● Not all areas of the home were clean. For example, some bedrail bumpers were soiled, there was debris along the side of overbed tables and dust on bedframes and chairs. There were drip marks on the tea, coffee and sugar cannisters and debris on the wall behind them in the kitchenette.

● The frames of some commodes and overbed tables were chipped or rusty, which made them difficult to keep hygienically clean. There were also worn bedrail bumpers and crash mat. Crash mats are used to minimise the risk of harm if a person fell from their bed.

● The provider completed an infection control audit in June 2022, there were shortfalls across all areas. An overall score of 57.6% was given. Such shortfalls included unclean areas, stained carpets and the poor standard of some flooring. The previous audit in April 2022, raised similar shortfalls throughout. This did not show sufficient action was being taken to ensure improvement.

● There was variable feedback about the standard of cleanliness within the home. One person said, "It's kept clean most days, the carpet is a bit soiled. A lady comes and cleans regularly. The other day she moved

the chair out, and it was very dusty underneath. Sometimes other staff come in and so called 'dust', but don't leave it very clean, or do much else." A relative told us, "The cleanliness isn't always great. The loo hadn't been cleaned for two or three days last time I came in, and there's stuff on the carpet down near [family member's] chair which has been there for ages."

Failing to ensure premises and any equipment are maintained in order to prevent and control the spread of infection was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were ample supplies of personal protective equipment (PPE) and staff wore it correctly. People and relatives confirmed this.
● Staff completed COVID-19 testing, as per government guidance and had received infection control training. This included putting on and taking their PPE off correctly. One member of staff told us, "We had extra infection control training. We were told it's everyone's responsibility."

Systems and processes to safeguard people from the risk of abuse
● Staff told us they had received training in safeguarding and knew how to recognise and report abuse or poor practice. However, a recent audit showed only 78% of staff had completed this training. Management told us staff on probation had not been included in this figure, so all staff had undertaken initial training and three were due refresher training.
● There were clear safeguarding policies and procedures in place. In a recent survey, it was identified that 91% of staff were familiar with the whistle blowing procedure.
● The manager described an open approach to reporting any safeguarding concerns which occurred. They said they were transparent and always looked at any learning that was required to minimise the risk of recurrence.

Using medicines safely
● There had been three recent safeguarding alerts regarding errors with medicines. The manager had investigated the errors appropriately and taken forward any lessons learnt.
● An electronic system for administering medicines was used. The electronic records showed people received their medicines, and had their topical creams applied as prescribed.
● The temperature of the rooms and refrigerators where medicines where stored were monitored and maintained at safe limits. A random check of controlled medicines showed an accurate stock balance.
● Registered nurses administered time specific medicines on time. However, guidance to ensure people received maximum effectiveness from their 'as required' medicines was limited. For example, guidance for one person stated, 'For relief from agitation', whilst information for another person was missing.
● There were up to date photographs of people in place, which were dated to indicate a true likeness of the person. This minimised the risk of medicines being given to the wrong person.
● Incidents involving medicines were reported appropriately, and discussed with staff to minimise the risk of recurrence.

Visiting in care homes
● People's relatives and friends were encouraged to visit at any time in line with government guidance.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Supporting people to eat and drink enough to maintain a balanced diet

- People were not supported to have enough to drink. Monitoring systems were not effective.
- During the inspection, the weather was very hot and sunny. Two people told us they were thirsty. One person had a small amount of water in a glass by their side but said it was warm and not good to drink. They asked if we could get them something else. We alerted staff to this, and a staff member poured water from a jug which was on their chest of drawers. This was equally as warm, as it had been standing in the person's hot room. They gave the drink to the person, who took a sip and shook their head. The staff member did not recognise the person needed a fresh cold drink of their choice.
- Despite the hot weather, staff did not encourage people to drink plenty. People consistently did not have drinks in front of them, which they could reach or manage independently. Following the inspection, the provider told us ice lollies were offered to people.
- Monitoring records did not show people had enough to drink. For example, the fluid intake records for one person showed nothing was drunk on one day, and 480mls was offered and 350mls was drunk on another day. Some intake had been recorded in the person's daily records, but this still showed a low amount. This was of particular relevance because of the hot weather at the time. There was no information to show staff had escalated any concerns about people's poor fluid intake. Neither the registered nurses or the management team had documented anything to show they had checked the records or were aware of the poor intake. One member of staff told us, "If there was more staff, it would be easier because I would allocate a set number of residents to staff to make sure they push drinks."
- There was a lack of delegation of responsibility for fluid monitoring. None of the staff we spoke with were able to confirm they were confident that people had received enough to drink.
- Staff had documented when people had declined food or drinks. However, the records did not always show that staff had returned and offered again, or that alternatives were offered or given.
- Food intake records lacked detail. Staff had not always written what people had eaten. Instead they had written statements such as, "Had lunch, the vegetarian dish, had a standard portion." There were gaps where nothing had been documented, and some records were contradictory. This included, "Had tea, ate nothing, had a standard portion." This meant it was difficult to assess whether people were eating a nutritionally balanced diet and exactly how much they had eaten.
- A recent audit had identified fluid and food monitoring was poor. For example, amounts of fluid intake were recorded as low as 30mls and those at risk of malnutrition, were not being properly monitored. This had been identified in an earlier audit, so was a repeated shortfall.

Failing to accurately monitor and ensure that people had access to enough food and drink was a breach of

Regulation 14 (meeting nutritional and hydration needs) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were generally happy with the food, but there were some comments that it was not always hot. One person said, "The food is ok, I shouldn't complain, and perhaps I'm a bit fussy. It's edible, but not delicious, and it's not hot when it arrives. I would like a small portion, but they always give me too much, which is off putting." Another person said, "The food is very good actually, they give you a choice for breakfast, your main meal and tea."
● There was a rolling menu, and people had a choice of meals. However, when asked, there had not been any alterations to the menu in response to the very hot weather. Later in the day, it was confirmed an alternative to the hot meal was being considered. Following the inspection, the provider told us there were always alternatives to a hot meal.

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.

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.
● Consent to care was not always sought in line with guidance.
● People were assessed for their ability to consent to their care and support. However, when people were unable to consent, mental capacity assessments had not always been carried out and best interest decisions had not always been documented. This did not show how decisions had been reached.
● One person had bed rails in place and their care plan referred to use of a sensor mat. Staff had documented there were MCA's in place and a DoLS application had been sent. However, no assessments were evident. There was no documentation to show how the decision to use the equipment had been reached, or what other less restrictive options had been considered.
● In another person's care plan, staff had documented bed rails should be used. There was no capacity assessment or best interest documentation in place for the use of the bed rails.
● A recent audit had identified MCA's were not always in place or decision specific. This had also been identified at a previous audit so was a repeated finding.

Failure to assess people's mental capacity and failure to ensure people's consent to care was sought was a breach of Regulation 11 (Need for consent) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some people had signed to confirm they consented to aspects of their care. Some people had signed a consent form for the use of photographs.
● Staff sought consent to care interventions such as providing people with clothes protection at lunchtime. They also sought permission to remove empty plates, and asked people if they were ready for their dessert. One member of staff said, "I ask people, 'Would you like to come and have a little walk with me to the

bathroom? Then, while we're here, would you like to use the toilet?'"
● Staff told us they had received training in the MCA.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were assessed prior to moving to the service and thereafter.
● The registered manager told us they undertook assessments and were careful to ensure people's needs could be met before agreeing the placement. Those people who were admitted to the intermediate care service had been assessed to ensure it was appropriate for them.

Staff support: induction, training, skills and experience
● There was a staff training plan, which was deemed mandatory by the provider.
● Staff training was generally 'on-line' although more recently there were some was face to face learning. The registered manager told us subjects such as emergency first aid and moving people safely were always completed face to face.
● Records showed staff were up to date with their training. Subjects covered included basic first aid, health and safety, dementia awareness and diabetes. However, some staff were waiting for more clinical training.
● One to one support meetings with staff, and appraisals to reflect on their performance took place. An audit had identified work was needed and was being undertaken, to make these processes more effective.
● There was variable feedback about how supported staff felt. One member of staff told us, "I only feel a bit supported." Another said, "[Staff name] has done supervisions with me. I feel supported by them." A recent survey showed 69% of staff strongly agreed or agreed they were supported and enabled to carry out their role.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People had access to a range of services to meet their healthcare needs.
● A GP visited weekly to review people's health. Staff told us GPs could be contacted easily for advice, and would also see people on request as needed.
● Records showed people were reviewed by tissue viability nurses and speech and language therapists as required.
● There was a rehabilitation support team who attended the service daily throughout the week to support people with their rehabilitation needs. One of the support team told us, "I think the [rehabilitation] service does work. We get a range of client needs here, but for the majority of patients their goal is to get home, no matter what."

Adapting service, design, decoration to meet people's needs
● Action plans were in place to improve the environment and work was taking place.
● At the time of the inspection, a new bathroom was being installed which included a specialised hydro bath, and a room was being converted into a hairdressing room. Works included adding a window in the corridor, to enable the room to have more light and be more spacious. The sun-room was also being refurbished.
● Senior managers told us various areas had been refurbished to ensure a more pleasant environment for people. An action plan also identified a range of planned improvements. Work had included refurbishment of bedrooms and the dining area and redecoration of the corridors. Senior managers told us further work was planned, which included solar panels to ensure greater sustainability.
●There was equipment in place such as handrails and toilet frames to help support people with their mobility.

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
- People rights to privacy, dignity and independence were not always promoted.
- People who used the service who were female, gave us variable feedback about male staff supporting them. One person told us they found this embarrassing and it made them feel vulnerable. This was particularly so if there were two male staff supporting them with personal care. Another person said, "I don't mind male carers. I wasn't asked how I felt about it, but their kindness and friendliness overrides any embarrassment." People could not remember being asked about their preference of being supported by a male or female member of staff.
- Two people who needed staff assistance and a hoist for their mobility, told us they were never helped to sit on the toilet. They both told us they opened their bowels into a pad, even though they had some sensation when they needed to do this. This did not promote their dignity or overall wellbeing.
- We saw one person come out of the passenger lift. They had been incontinent and there was urine on their trousers. A member of the ancillary team gave reassurance, helped them to the bathroom and called an agency staff member to assist. The agency staff member said they would help the person change their clothes and directed them to their room. The staff member collected a red disposable bag for the soiled items, and waited in the doorway of the person's bedroom until they got there. There was no interaction or reassurance, and the person had to walk past a seating area in noticeably soiled clothing.
- There were various examples of staff promoting people's independence. This included one staff member carefully positioning a spoon to enable a person to eat independently. One person did not want staff assistance, but staff were attentive, and once they noticed the person struggling, they offered to help again. They discreetly help to cut the person's food up, and then left them to carry on eating.
- Records showed staff had completed equality and diversity and dignity training.

We recommend the provider ensures all staff are aware of the need to treat people with dignity and respect including those staff who are not directly employed by the service such as agency staff.

Ensuring people are well treated and supported; respecting equality and diversity
- Staff treated people with kindness and compassion.
- Most people spoke positively of their relationships with the permanent staff, and some regular agency staff were also mentioned by name, as being particularly caring. A person told us, "[Name of staff] is very good, really kind and will sometimes come in after work and sit with me for 5 or 10 minutes. [Name of staff] comes in too and is very nice. He makes the time he spends with you count." Another person said, " They're the best bunch of people I've ever met, they're fantastic." A relative told us, "I see the change in [family

member's] expression when his favourite comes up to him. He beams and you can see that there's a good relationship."

● There were various examples of good interactions with people. For example, a member of staff approached a person and said, "Are you OK? You seem upset? Oh, my lovely, talk to me." The person was quietly crying, and the staff member sat with them and wiped away their tears. They were gentle and caring and stayed until the person was settled.

● One member of staff looked at a book with a person in the lounge. They were pointing to different things, which enabled the person to reminisce. The staff member was attentive and encouraged this, by listening and responding to what the person was saying.

● Whilst there were good interactions, some agency staff did not demonstrate positive engagement with people. This included walking around the lounge with no interaction with the people who were sitting there, or when undertaking an intervention. Some people confirmed this and said some agency staff did not speak to them when providing care or when delivering a meal. One person said, "Some of them don't speak to you at all."

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

● People gave us variable feedback about being able to make decisions about their care.

● Some people told us they could choose their own routines such as getting up and going to sleep. However, not all said they could have a shower when they wanted one. One person told us, "I had a shower about two weeks ago. I once asked one of the permanent staff, who refused and said quite rudely that they were too busy."

● Staff told us they encouraged people to make decisions, as far as they were able. One staff member told us, "I always ask people what they want to do as we go along." Another staff member said, "When I'm helping someone get dressed, I'll hold up two items [of clothing] and ask them to choose."

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. At this inspection the rating has changed to 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

- People did not always receive personalised care which met their needs, and care planning was not always effective.
- One person had their heels out of their slippers, and they were on the wrong feet. The person's feet were soiled, and their slippers were stained. Their feet and clothing had a strong odour. Three other people's fingernails had brown debris underneath and around the edges. One of these people's nails were long and ragged. They said no one had offered to cut them.
- One person told us, "The only thing is my false teeth. There used to always be someone coming around last thing to settle you down and they'd put your teeth in to soak. That doesn't happen anymore. My teeth are often on the table all night, drying out and they don't get properly cleaned, or I leave them in which you aren't supposed to do. I shouldn't moan because it's a little thing, but it matters to me. I have to 'bully' them for a shave now and then, they're terrors for letting things like that go." A relative told us, "[Person] has been here six weeks from hospital but they haven't been helped out of bed. They were taking steps when they arrived and have gone right down. They're just in bed and haven't had any exercises". After the inspection, the provider told us this person's support was directed by the specialized team responsible for the local authority's early discharge programme so there would have been a reason for this.
- The management team told us there were currently seven people with wounds. These were of varying degrees. The wound care plans contained photographs, but a measuring tool was not visible in the pictures and staff had not recorded any wound measurements. In addition, the condition of the wound and surrounding tissue had not been assessed using the tool within the care plans. This meant it was difficult for staff to clearly identify if wounds were improving or deteriorating.
- Care plans specified how often people needed to be supported to change their positions in order to relieve pressure. Records generally showed position changes took place as directed. However, there were some periods when people's positions had not been changed as per care plan guidance. For example, one person's plan directed staff to change the person's position every three hours. Over a three-day period, there were five occasions where there was a gap of over three hours. On one occasion there was a gap of four and a half hours, and on another occasion, there was a gap of five hours and fifty minutes.
- Care plans did not always contain information which reflected people's daily records. For example, in one person's daily records, staff had documented the person had been sexually inappropriate, but there was nothing in the care plan to inform staff how they should respond to this.
- Some care plans were person centred and included details of people's choices and preferences for how they wanted staff to support them. However, this was not consistent. A recent audit had identified this, and plans were in place for additional training for staff. Writing care plans in a more personable way had also been discussed in a recent staff meeting.

Failure to ensure that each person received appropriate person-centred care and treatment that is based on an assessment of their needs and preferences was a breach of Regulation 9 (Person-centred care) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● The service met the AIS.
● People's communication needs had been assessed. When a person needed staff support, this information was included in their care plan. This included ensuring people wore their glasses or hearing aids.
● Care plans detailed how staff should support those people who found verbal communication difficult. For example, in one person's care plan it was documented their speech difficulties were worse when they were tired, or frustrated. There were examples of when this might happen, as well as informing staff what they should do to help.

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
● Specific staff were employed to arrange social activity provision, but people told us there was not enough for them to do.
● Some people told us they were happy to follow their solitary interests such as doing a crossword, watching television or listening to music. However, other people spoke of feeling lonely and isolated, with little choice of activity. One person told us, "I'd go outside if I had the chance. I don't do anything but sleep most of the time now. I used to enjoy the garden but it's too much trouble for the staff, they can't do it." Another person said, "There's absolutely no activities. You'd think there'd be something like Bingo, which I've never played in my life, or singing."
● An entertainer visited the home during the inspection, which people enjoyed. People were clapping and complimentary about the event. An exercise group was identified on the activity plan. A staff member asked people in the lounge if they wanted to do this, but no one did. It was a very hot day, yet this had not been taken into account.
● In the morning, one of the activity staff visited people in their rooms as well as communal areas, offering a glass of sherry. They said this was a daily occurrence, which was popular with some.
● Information about people's interests were shown in their care plans. This included the type of music people enjoyed listening to.
● However, some people sat in the communal lounge, and there was a programme on the television about politics. Nobody appeared to be watching it, but none of the staff who came into the lounge asked if they wanted it changed. At one point, a member of staff switched the television off, without asking anyone, and then put the radio on. They did not ask if anyone wanted to listen to music or what station.
● Some people chose to stay in their bedrooms rather than access communal areas. Staff respected this and tried to spend time with people when they could. However, some staff said this rarely happened. One staff member said, "We were told we could sit and chat with people, but the reality is we can't do that with three of us on duty on this floor. You can't sit and have a cup of tea with one person when someone else needs you."

Improving care quality in response to complaints or concerns

● Systems were in place to manage any complaints.
● People were encouraged to initially speak to the manager if they were unhappy about the service. They could also contact a senior manager if they preferred.
● A record of any complaints raised was maintained.
● People told us they would raise any concerns they might have, although not all knew who to speak to. One person told us, "If I had a complaint, I think I'd talk to [name], I think he's the manager's son as he came and introduced himself. I could also tell the nursing staff, but I don't think they'd be able to do anything or take any action. You'd need the manager for that." Another person told us, "I wouldn't know who to complain to. I don't know the managers, they don't come around, so I'd just tell one of the carers and I think they'd tell someone for me." One relative told us a member of their family had raised concerns but was satisfied with the outcome.

End of life care and support
● The home was able to provide care at the very end of a person's life. At the time of the inspection, no one was receiving this type of care.
● Staff told us they had received training in end of life care.
● A recent action plan showed end of life care planning was being developed.

Inadequate

Is the service well-led?

Our findings

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

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- Shortfalls in the service had been identified, and additional managers including a peripatetic clinical manager had been deployed to support the new manager in ensuring improvements were put in place.
- Such shortfalls included cleanliness, care planning, food and fluid intake monitoring, consent, call bell response times and staff training.
- Audits had identified a high number of wounds, pressure injuries and care interventions which had been missed within the expected timescales. For example, in June 2022, records showed there were 32 wounds, 10 pressure injuries and 21 missed interventions. In May, there were 30 wounds, 6 pressure injuries and 17 missed interventions.
- An extensive range of action plans had been developed. However, these were not being implemented in practice. For example, gaps in the food and fluid and repositioning monitoring records had been identified, but not addressed. The shortfall was therefore shown as a repeated action. This was the same for records which showed the support people received with repositioning to minimise the risk of pressure damage.
- Responsibility for the monitoring of people's care had not been clearly delegated. For example, the registered manager told us it was the responsibility of the registered nurses, to monitor people's fluid intake. However, a registered nurse said they relied on staff telling them that people had or had not had enough to eat. Another registered nurse told us they tried to keep a track of people's intake but it was difficult to do, with the other demands of the role.
- The registered manager told us they were happy with the service provided, but staff did not share this view. One member of staff told us they were not confident the standard of care was good. They said, "The nurses need to be constantly checking. We have different agency staff every day, and they need to be reminded every day the importance of reporting, turning, pressure wounds." Another staff member said "The pace has changed. It feels like a business now."
- The lack of staffing and high reliance on agency staff was significantly impacting the service. This impact had been fully recognised by the management team, and a strong focus on recruitment was taking place.
- The registered manager told us they regularly walked around the home to get to know people and to monitor practice. However, some feedback indicated a better management presence would be beneficial. For example, one person said, "I haven't met the new manager. I don't think they've been round. There isn't enough contact with the management. They should come around and ask how things are. I hope it's going to get better." A relative told us, "It's not well run. I've tried to arrange to meet the manager, the only time they've spoken to me is today."

The governance and quality assurance processes in place were not effective. This was a breach of Regulation 17 (Good governance) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● The service did not have a positive culture, although the management team were not aware of the extent of this.

● Staff told us they were stressed and morale was low. One staff member told us, "Sometimes I come to work, and it feels like a huge pressure. I'm just waiting for something [bad] to happen." Other comments were, "I am overloaded, and I feel frustrated", and, "Staff are friendly, but they are sad."

● Not all staff or people who used the service told us they would recommend the service. One person told us, "The atmosphere is friendly, the staff are friendly towards me and I've been quite happy from that side. I wouldn't recommend it because I've been left in bed, and I was hoping to get a lot more help, to get up and to try to walk again. It's also a very noisy place, especially at night." Following the inspection, the provider told us management undertook regular night visits and worked at night but had not experienced such noise.

● Whilst respecting the management view of the home being in line with the dependency tool the provider uses to calculate staffing numbers, this was not seen in practice. It was also not what people, their relatives and staff told us. One person said, "They are short staffed, especially in the evenings. There are only two staff at night. I'm last on their list because I'm not ill, and others need more attention than I do." After the inspection, the provider told us there were two staff in a designated area, not two staff for the whole of the home.

● The registered manager told us they were very excited about their role and the journey the home was on. They said they wanted to radiate their enthusiasm, and build on their vision of people being at the centre of all that was done. They told us they had made it clear to staff about their vision and their expectations.

● There were systems in place to enable the sharing of information. This included handovers, daily meetings with heads of departments, and other staff meetings.

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

● People gave us variable feedback about whether they were asked to share their views about the service. One person told us, "They've been round and asked if everything is alright and can anything be improved. I don't say yes or no, I keep quiet." Another person said, "I've never been asked what I think about things here. They don't do that."

● Staff told us they did not feel consulted, or that their views were followed through into practice. For example, one member of staff told us the management team often made changes, but staff were not always consulted about the effectiveness of what was proposed. Another staff member said, "It's so frustrating. I don't feel I can deliver the care these people deserve. There is not enough staff. I have raised concerns with virtually every manager, and I just get brushed off."

● People, their relatives and staff were asked to complete an annual survey. The feedback was coordinated and shown within a detailed report.

● The registered manager told us they would be developing opportunities for people, relatives and staff to share their views. They said they had started implementing meetings, and had had a lot of one to one conservations. They said they had an open approach, and were happy to be contacted at any time if needed.

● People told us they benefitted from their electronic devices. They said they found them useful to keep in touch with their family and friends, but also what was going on in the world.

● A new electronic device was being installed at the entrance area. This was to enable people, their relatives

and health and social care professionals to leave their feedback more easily.

Continuous learning and improving care

● The action plans in place and the deployment of additional managers demonstrated a commitment to improve the service.

● The registered manager confirmed the home was on a journey. They said they were not putting pressure on themselves with specific timescales, but felt it would be about a year before the home was stable and where they wanted it to be. They had recognised there was no 'quick fix', but were positive about the future.

● Some people and their relatives, however, were unhappy with the amount of progress being made. One relative told us, "I was hoping things would get better now it's been taken over, but it's not really impressing me at the moment. It's difficult to say if I'd recommend it as there are a few things irritating us at the moment as a family."

● People, their relatives and staff told us the biggest improvement to the service, would be more staff. One person said, "Definitely more staff. I shouldn't be waiting one and a half hours for help, and something to do, some sort of activity". A relative said, "The improvements to the building are good. I'd like to see better staffing and communication."

Working in partnership with others

● The manager told us as they were new in post, networking was being developed.

● There were good relationships with the local GP surgery, and other health and social care professionals. One professional told us they regularly visited and found the staff to be very helpful and willing to assist.

● The manager told us they had excellent support from senior managers and other departments within the organisation. This included the quality team and human resources.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	Care planning failed to ensure that people received appropriate person-centred care and treatment that was based on an assessment of their needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The service failed to assess people's mental capacity and failure to ensure people's consent to care was sought.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The service failed to identify and mitigate risks to people's safety, and failed to ensure the premises and equipment were maintained to prevent and control the risk of infection.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs
Treatment of disease, disorder or injury	The service failed to accurately monitor and ensure that people had access to enough food and drink.

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

There were insufficient numbers of staff to meet people's needs safely and effectively.

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 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The service failed to ensure the governance and quality assurance processes in place were effective.

The enforcement action we took:

We issued the provider a Warning Notice.