Mrs Hazel Teresa Boam

Masson House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Masson House is a residential care home providing accommodation and personal care to up to 17 people. The service primarily provides support to older adults but can also support people over the age of 18. At the time of our inspection there were 16 people using the service. The care home is a large adapted domestic style building, which also has a purpose-built ground floor extension.

People's experience of using this service and what we found
People were not always protected from potential abuse. The provider did not ensure all allegations of potential abuse were notified to the local authority or CQC. People were not always protected from the risk of potential harm from scalding, burns, or legionella infections. A suitable fire safety risk assessment was not in place.

People's medicines were not always safely managed, administered, or recorded consistently. Guidance for staff on people's individual medicines was not always accurate. People were not always supported by enough staff to meet their care needs.

People lived in a care home which was not always clean. There was an unpleasant urine odour present in several areas of the care home. The laundry room had evidence of black mould present which was a potential risk to people's health.

People had not been appropriately assessed to determine if they had the mental capacity to consent to live at the care home. People were effectively deprived of some aspects of their liberty, but the provider had not applied for authorisation from the relevant local authority. One person told us they did not want to live at Masson House but there was no evidence found that they were being supported to move to a different care home

People's care plans were not regularly reviewed and contained contradictory information about people's care and support needs. The provider was not able to evidence all staff had received the necessary training to enable them to care for people safely.

People had limited meal options offered to them and their preferences were not always identified and actioned. People were not always supported to access specialist advice from external healthcare professionals in a timely manner.

People told us they found the care home was sometimes cold and staff told us they did not have access to the heating controller to enable them to increase the temperature in the care home. People were not always supported to receive their 'as and when required' medicines in a timely manner, which had a particular impact on people who had been prescribed pain relief medicines.

Staff respected people's privacy when providing personal care support, and people were supported to dress appropriately to maintain their dignity. People were not often supported to take part in organised activities at the care home. People on end-of-life care did not always appear to be treated with compassion and empathy.

People were not supported to have maximum choice and control of their lives and the provider did not have suitable processes in place to ensure potential restrictions on people's liberty were legally authorised and in their best interests; the policies, systems, and practice in the service did not take into account the requirements of the Mental Capacity Act 2005.

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. We considered this guidance as there were people using the service who have a learning disability and/or who are autistic.

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 11 January 2018)

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

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

You can see what action we have asked the provider to take at the end of this full report. The provider has told us they will take action to address the issues we found. Please see the Safe, Effective, Caring, Responsive, and Well Led sections of this full report.

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

Enforcement
We have identified breaches in relation to safety, safeguarding, medicines management, staffing, hygiene, consent, and the management of the service at this inspection.

We imposed conditions on the provider's registration with CQC, requiring the provider to send us assurances they had taken the required action to ensure people were safely supported. Please see the action we have told the provider to take at the end of this report.

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.

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

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

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Masson House

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 prevention and control 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 initial 3 inspection site visits were carried out by 1 inspector. The 4th inspection site visit was carried out by 2 inspectors.

Service and service type
Masson House 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. Masson House is a care home which does not provide 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 registered manager in post.

Notice of inspection
The inspection visit on 23 August 2023 was unannounced. We returned, announced, on 24 August 2023.

Further, unannounced, inspection visits took place on 5 September 2023 and 28 September 2023 to complete the inspection information gathering process.

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 used information gathered as part of monitoring activity which took place on 17 July 2023 to help plan the inspection and inform our judgements. We used all this information to plan our inspection.

During the inspection
We spoke with 12 people who used the service about their experience of living at the care home. We also observed staff interactions with people. We spoke with 6 members of staff including carers, cook, deputy manager, day manager, and the registered manager. We reviewed a range of records. These included elements of 2 people's care records and a sample of people's medication records. We looked at 3 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures, were reviewed.

We received feedback about the service from 3 external professionals who had recent and ongoing involvement with the service. We received feedback from 3 relatives of the people who lived at the care home. We also received feedback, by phone or email, from 5 staff.

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

- People were not always protected from the risk of abuse. The registered manager did not take appropriate action when allegations of verbal abuse of people were received. This placed people at an increased risk of harm.
- Some people had experienced bullying and verbal abuse from a staff member at the care home. One staff member told us, "A lot of staff, and some of the residents too, have raised concerns about one of the staff shouting at the residents. I have voiced my concerns to [registered manager] but nothing happened about it. Nothing gets reported."
- Another staff member told us, "Residents have complained about a staff member being horrible and nasty towards them to a few of us and we've told the manager."
- The inspector raised this with the registered manager, who told us they had attempted to deal with the issues previously by talking with the staff member and people concerned.
- There was no evidence the registered manager had reported the allegations of abuse to either the local authority safeguarding team or to the CQC. This meant people were not safeguarded from the risk of abuse. The inspector notified the local authority safeguarding team.
- Not all staff had received safeguarding training and the provider did not ensure regular refresher training was provided to those who had received the training some years previously. A staff member told us, "I have been here for a while and have never done any safeguarding training while working here."
- The provider had a safeguarding policy and procedure, but this was not readily available and accessible to all staff. There was no evidence that care staff had read it. This meant staff did not have easy access to guidance from the provider on how to escalate concerns externally if they felt they weren't being responded to appropriately by the registered manager.

The provider's systems and processes failed to safeguard people from the risk of abuse and improper treatment. This placed people at increased risk of harm. 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 not always protected from the risk of scalding. Several hot water outlets, including a shower, were not appropriately temperature controlled which increased the potential for people to be scalded.
- People were not always protected from the risk of burns. Several radiators, and exposed areas of hot water pipework, were not appropriately covered, which increased the potential for people to be burned if they fell against them.
- People were not appropriately protected against the potential risk of legionella infection. Legionella is an

infectious waterborne disease that can cause serious ill health. An inadequate risk assessment was in place, which failed to identify the actions the provider needed to take to reduce the potential risk of legionella bacteria build up.
● Water temperatures were not being checked regularly or appropriately. There was no evidence of action taken when the water was found to be outside the safe temperature ranges. This meant there was an increased risk of potential legionella infection.
● People were not always protected from the potential risks associated with fire. The provider did not have an appropriate fire risk assessment in place at the time of the inspection. This meant the provider had not adequately assessed potential fire risks or the actions which should be taken to mitigate them.
● Deficiencies in some fire doors were also observed. This meant there was potentially an increased risk of injury to people in the event of a fire.
● People were not always protected from the risk of falls from height. Several windows were observed not to have window opening restrictors on them. This meant there was an increased potential risk of people falling from height.

The provider failed to adequately assess the risks to the health and safety of service users receiving care. They also failed to take action to mitigate any such risks as far as is reasonably practicable. This placed people at increased risk of harm. This was a breach of regulation 12(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The inspector raised the issue of window restrictors with the registered manager who subsequently arranged for restrictors to be fitted to some windows.
● The inspector notified the Fire and Rescue Service about their observations. A Fire Officer subsequently visited the care home and separately wrote to the provider about fire safety matters and requirements.

Using medicines safely
● People's prescribed medicines were not managed safely. For example, people's prescribed controlled drugs were not stored safely or securely. Controlled drugs are subject to high levels of regulation; and are drugs which are especially addictive and harmful.
● People's controlled drugs were stored in a lockable wall box in the laundry room. The key to the lockable wall box was observed to be left in the lock unattended. This increased the risk that controlled drugs could be accessed by people without proper authorisation.
● The laundry room had visible mould present, was poorly ventilated, and was not temperature controlled. No temperature checks were carried out by the provider to ensure the controlled drugs were stored at below 25 degrees Celsius. This meant controlled drugs were not stored safely.
● People's medicines, which were in daily use, were stored in the provider's medicines trolley located in the dining room, directly in front of a window. This was not a temperature-controlled area, and temperature checks of the medicine trolley had not been carried out by the provider. This was raised with the registered manager who subsequently arranged for the temperature of the medicine's trolley to be recorded each day.
● People's prescribed topical medicines were not always administered in line with the prescriber's instructions. A topical medicine is one which is applied to a particular place on the person's body.
● Two people had prescriptions for skin creams to be applied to them regularly by care staff. However, the provider's medicines record system contained inconsistent records of the prescribed skin creams having been applied to either person.
● People did not always have appropriate medicines profiles in place. These guide care staff on the types of medicines each person has been prescribed, the reasons for the prescription, and any side effects or risks to be aware of.
● Some people had no medicine profile in place, and other people had medicine profiles which stated they

fully understood their medicines, and why they were taking them, when that was not the case. The provider's medicines profile therefore contained inaccurate information about whether the person had consented to receive their medicine. The lack of accurate information increased the potential for mistakes to be made and for people to be harmed.
● The registered manager told us that no-one received their prescribed medicines covertly. However, staff told us a person did receive their medicines hidden in a drink. There were no records to demonstrate that had been discussed and authorised by the prescriber, or of an assessment of whether it was in the person's best interest to administer medicines in that way.
● Staff told us they had seen medicine errors occur and had also observed medicines being left unattended near people. This increased the risk that a person may take someone else's medicine.
● Staff told us the registered manager did not want medicines incidents to be recorded or reported. This meant opportunities to monitor and correct medicines errors were missed.

The provider failed to ensure the proper and safe management of medicines. This placed people at increased risk of harm. This was a breach of regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The inspector signposted the provider to guidance on the safe management of medicines in care homes.

Staffing and recruitment
● People were not always supported by enough staff to meet their care needs.
● The provider's dependency assessment tool was inadequate and did not demonstrate a systematic approach to determining the number of staff required to meet the care needs of people living in the care home.
● The 16 people living at the care home at the time of the inspection were supported by 2 care staff in the afternoons and all day at the weekends. There was no explanation available as to why 3 care staff were required on weekday mornings, but only 2 care staff required on weekend mornings.
● Some people required 2 staff to assist them with moving and handling tasks. One person had been assessed as needing a staff member to be with them as they ate, to decrease the risk of choking. Some people were being cared for in their bedrooms. This meant there were times when the 2 staff would both be supporting 1 person, leaving the other people unsupervised. This increased the potential risks that people might be harmed.
● One staff member told us, "There just aren't enough staff on in the afternoons or weekends. We only have 2 on, so we are limited in what we can do with people. Plus, sometimes both of us will be needed to be supporting one person with something, so that means no one is keeping an eye on all the others."
● One relative told us, "I sometimes can't find a single staff member when I visit. I often have to just let myself in because no one answers the door when I arrive. I don't think they have enough staff. You never really see any of the staff having the time to just sit and chat with the residents."

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

● The provider's staff recruitment records, reviewed at the care home, did not always contain the required information in respect of staff work history and proof of identity. For example, we reviewed 3 staff records and found that each had some required information missing, such as evidence of a DBS check, a full employment history, together with a satisfactory written explanation of any gaps in employment, and a recent photograph.

● Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● The inspector signposted the registered manager to guidance on the records required to be held in respect of each person employed to work with vulnerable people.

Preventing and controlling infection
● People lived in a care home which was not always clean. For example, the laundry room had patches of black mould on the walls. Laundered clothes and medicines were stored in that room. Moulds produce allergens (substances that can cause an allergic reaction), irritants and, sometimes, toxic substances. This was raised by the inspector with the registered manager who arranged for black mould to be cleaned from the walls in that area.
● There was a strong odour of urine on entry into the care home, and in several bedrooms and ensuite areas. Some ensuite toilet rooms had gaps between the floor and skirting boards which hampered effective cleaning and deodorising. This was raised by the inspector with the registered manager who then arranged for the gaps to be sealed.
● Effective cleaning was not always taking place which meant some areas were not clean. Rota records showed cleaning staff were often not on duty on several days each week. This meant routine cleaning tasks had to be carried out by care staff, which took them away from providing care to people.
● One staff member told us, "Care staff are supposed to do the daily cleaning as we go along, but there just isn't time to do a proper job of the cleaning. Some of the rooms smell really badly of urine because it has soaked into the flooring and carpets. The cleaning is terrible at times." Another staff member told us, "There's never a cleaner on every day… and it's definitely the most unclean the home has ever been. It smells unpleasant and we have no cleaners at weekends."
● The provider did not have a current infection prevention and control policy and procedure in place, which was readily available to guide staff, at the time of the inspection.

The provider failed to maintain appropriate standards of hygiene and cleanliness. This placed people at increased risk of harm from health infections. This was a breach of regulation 15(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were not always protected from food hygiene related risks. The provider had improved their Food Safety rating to a '4 star' following a reinspection by the local authority Environmental Health Inspector in June 2023. However, in this inspection we found some of those improvements had not been sustained.
● For example, prepared foods were found without date labels in the refrigerator, some stored vegetable and fruit items were not fit for consumption, and measures to keep the kitchen free from insects were not effective. This increased people's potential risk of food related health infections.
● The inspector raised the food safety concerns with the registered manager, who subsequently arranged for catering staff to be reminded of food safety requirements and installed a suitable flying insect control device. We found the kitchen hygiene had improved when we revisited.
● The provider supported visits to the care home in line with the government guidance in place at the time of the inspection.
● The inspector signposted the provider to resources to develop their approach to infection prevention and control, and hygiene.

Learning lessons when things go wrong
● The provider did not consistently identify or address safety concerns quickly. For example, the issues with water temperature control and the storage of controlled medicines; mentioned earlier in this section of the

inspection report. These were raised by the inspector with the registered manager on the first inspection site visit, but effective action had not been taken by the time of our final site visit over 1 month later.

● The provider had limited systems to record and report safety concerns, incidents and near misses. The provider had a rudimentary incident monitoring process in place, but copies of previous incident reports, or details of actions taken to reduce the likelihood of recurrence, were not available to review at the care home.

● Some staff told us they were wary about raising concerns with the registered manager. For example, a staff member told us, "The staff really care about the residents, but when we raise concerns, nothing changes, and we are worried that we will get into trouble." This meant opportunities were missed to learn from concerns and improve the service people received.

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.

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 provider had not appropriately assessed people to see if they had the capacity to make certain decisions. The registered manager told us none of the people living in the care home had a DoLS authorisation in place.
- Staff told us some of the people needed consistent supervision and would not be able to leave the care home, if they decided to, because it was considered unsafe for them to do so. This meant people's liberty was effectively being restricted.
- A staff member told us, "No one has DoLS in place here. We have done the training so we know some of them should have a DoLS authorisation in place from the local authority, but [registered manager] hasn't applied for any. Most people wouldn't be safe to leave the care home without staff or someone being with them, and some people need to be kept an eye on most of the time here because they might need help."

The provider failed to ensure care and treatment was only provided with the consent of the relevant person. This was a breach of regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- People's care plans were not always regularly reviewed. The provider's electronic care record system indicated when care plan reviews were needed, and some aspects of people's care plans were overdue for review by several months. This increased the risk that people would receive poor care.

● People's care plans contained contradictory information. For example, a person's care plan showed they were known to be at risk from choking on food and stated a staff member should be continuously with them as they ate. However, elsewhere in the person's care plan, it stated it was sufficient just to check the person regularly as they ate. This contradiction increased the potential that the person would receive inconsistent or unsafe care.

Staff support: induction, training, skills and experience
● The provider did not have a consistent approach to supporting staff to achieve and maintain their professional skills or knowledge of best practice.
● The provider was requested to send the inspector a copy of their electronic staff training matrix, which showed details of all the training the provider's staff had received and the dates when any refresher training would be needed. The provider failed to send the inspector a copy of this training record. This meant the provider did not evidence staff were appropriately trained to carry out their work safely.
● A staff member told us, "Since you started your inspection, I am now being asked to do a lot of the online training because [registered manager] is trying to make things look better for CQC."
● Another staff member told us, "All training is on the laptop which we keep in the office and staff go to do that while on shift. But it's impossible to sit and concentrate when buzzers are going off, even if you find a minute in your shift to do so."
● Staff did not always implement their training in practice. A staff member told us, "We have moving and handling training, and we all learn how to do it properly, but then [registered manager] just over rules the training and tells us how they want us to do it." This meant people were at increased risk of harm or of receiving poor care.

Supporting people to eat and drink enough to maintain a balanced diet
● The service did not always involve people in choosing their preferred meals. For example, a person told us they preferred a cooked breakfast occasionally, but options were limited to toast or cereal.
● One staff member told us, "They can't have a cooked breakfast or even anything like a bacon sandwich or a sausage sandwich. That's because it takes more time to cook."
● The inspector raised this issue of choice with the registered manager, who told us, "We are happy to provide a cooked breakfast." However, the registered manager stated a 'cooked breakfast' was a tea-time option, not a morning breakfast option. They told us they would discuss that with people at the next resident's meeting.
● The provider's catering staff sometimes started work at 9am, which was after breakfast had started to be served to people. This sometimes meant a member of the care staff had to prepare people's breakfast as well as carry out care tasks. This increased the risk that people may not be supported to eat and drink enough.
● The provider's menu records did not evidence people received a choice of their main lunch meal. The written menu planner and kitchen diary record of actual meals provided did not indicate any alternative menu options were available for people.
● There was a lack of choice, however, people told us they enjoyed the main lunch meals they received. The food was prepared at the care home and appeared appetising. A person told us, "The food is lovely here. I like whatever they give me."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People's care plans were not always informed by specialist health care advice. For example, the provider's care plan for a person stated they required a soft food diet due to a known risk of choking. However, there was no evidence the person had been referred to a speech and language therapist (SALT) for a specialist

assessment of their needs. This increased the risk of the person being provided with food in a form which was not safe for them.

● Another person had a written SALT assessment and guidance document in place, due to their increased risk of choking when eating, but there were no details of that assessment or guidance in the person's care plan for staff to refer to. This increased the risk that staff would not support the person in line with the specialist healthcare advice.

● People were not always supported to obtain the health care treatment and equipment they needed. An external healthcare professional told us there were delays from the care home in supporting people to have their prescribed medicines reviewed by a GP when their needs changed, and that the registered manager did not always order required items of equipment in a timely manner.

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

● People did not always feel warm enough in the care home. A person told us, "I can't understand why we have no heating. That's why I have double sweaters on at the moment." Another person told us, "I feel cold. But then I always feel cold, perhaps it's because I am ill?" The inspector checked and found the radiators in people's rooms were not on.

● A third person told us, "It's always cold here. I haven't got a radiator in my room." The inspector found that part of the care home had underfloor heating instead of radiators. However, the underfloor heating was turned off at the heating controller.

● People were sat in the lounge and garden room with blankets over their legs which had been given to them by care staff. This indicated people were feeling cold.

● The inspector raised this with care staff on duty who told us they were not able to turn the heating on because access to the thermostat was controlled by the registered manager and they had now left the care home for the day.

● People were able to personalise their bedrooms. Aside from the cleanliness and hygiene issues mentioned in this report (See Safe section above) the care home decoration was generally homely.

● People had limited access to external garden areas, but some people enjoyed using the front porch/balcony area as a place to sit and enjoy spending time. The care home extension also included a conservatory type 'garden room' which people used if they wanted to spend time away from the lounge.

Inadequate

Is the service caring?

Our findings

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

At our last inspection we rated this key question Good. At this inspection the rating has changed to Inadequate. This meant people were not always treated with compassion; there were significant shortfalls in the caring attitude of some staff.

Ensuring people are well treated and supported; respecting equality and diversity
- People told us they were not always treated with compassion and kindness. People told us a staff member was rude and shouted at them, as also described in the Safe section of this report (above).
- Staff did not always respond in a timely manner when people said they were in pain. For example, a person had a prescribed strong pain relief medicine for chronic pain but did not always receive it when needed, or in accordance with the prescriber's instructions.
- During our inspection visits we twice observed the person to be in pain. We raised this each time with the care staff who then gave the person their prescribed medicine. We later found the dosage given was less than had been prescribed and, although prescribed to be given 'as and when required' 4 times a day if needed, it was routinely given to the person once per day.
- People told us care was often rushed. One person told us, "Most staff are alright, but [staff member] is very short tempered and hasn't any patience. Would be nice if there were more staff. I get lonely in my room. It would be better if the staff had more time to talk but they haven't."
- Another person told us, "Staff are varied. They don't do everything according to plan some of them. Takes them a while to learn what to do."
- People's care plans did not contain details of people's individual needs in terms of equality and diversity. This increased the risk of receiving care which did not meet their needs.
- The registered manager provided no evidence during the inspection that the care home staff had received training to help them to understand people's equality and diversity support needs.

Supporting people to express their views and be involved in making decisions about their care
- People were not involved in making decisions about their care, such as being involved in their care plan reviews. One person told us, "They [staff] don't do the things you would like them to."
- One person told us they did not want to live at Masson House and that no one from the care home management, or the local authority, was helping them to find an alternative place to live. There was no record made in the person's care notes that they wanted to move to a different care home.
- People were not supported by the provider to express their views on the service they received. The registered manager told us that resident meetings and satisfaction surveys were regularly carried out, but no evidence of that was seen.

Respecting and promoting people's privacy, dignity and independence
- Some people were supported to remain as independent as possible, and some people were able to visit the local community without staff support.

- Staff respected people's privacy when providing personal care support.
- During all the inspection site visits people were seen to be appropriately dressed to maintain their dignity.

Inadequate

Is the service responsive?

Our findings

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

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

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

- People's care plans had not been regularly reviewed or updated. This meant there was an increased risk that care plans did not accurately reflect people's current personalised care needs.
- People's meal preferences and mealtimes were not responded to flexibly. A staff member told us, "About the choice of food, there isn't any really. They get drinks at set times, meals at set times, and they have the food that is cooked for them." This meant people's individual food preferences were not always being identified and met.
- Some people living at the care home, who were relatively independent, did receive aspects of more personalised care. For example, the provider enabled 1 person to prepare their own drinks and snacks, as they did not require any staff assistance to do that.

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 provider did not appear to understand the requirements of the Accessible Information Standard. No evidence was seen of any provider information/documents for people created in formats which would help to ensure people with a disability or sensory loss could understand it.
- Staff understood how each person preferred to communicate verbally. Staff understood people's verbal communication and people understood what staff were saying to them.

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

- People were seldom supported by the provider to take part in organised activities. The registered manager told us this was because of the level at which the care home was funded and said people and their relatives understood activities offered to people would be limited.
- People sometimes felt isolated. A person told us, "I stay in my room mainly, because no one speaks to you down there, so I do my reading up here. If there were people doing things we could join in with, then that would be great, the ideal thing."
- Another person told us, "We used to do quizzes and games in the lounge, but we haven't done any for ages, that doesn't make me feel very good. There are not enough staff to do activities."

● One staff member told us, "Residents sit and watch TV all day. When I did activities, they enjoyed it and it got them all engaged, and their faces light up! More activities are needed even if it's for half an hour a day; something to look forward to and can be from care staff, not necessarily people coming in if extra costs are the issue."
● Another staff member told us, "Since you have started visiting [registered manager] told us we need to start doing activities with people because CQC are looking at the care home. They told us to do them in the afternoons, but there are only 2 staff on the afternoons, and we just don't have time to do activities and care for people; some of them are in their rooms and we need to keep an eye on them and give them care there."
● The provider had an activities timetable board, which showed an activity scheduled for each day. However, people and staff confirmed those activities did not happen.

Improving care quality in response to complaints or concerns
● People were not regularly invited by the provider to express their views on the care and support they received.
● The provider's response to complaints and concerns being raised suggested a defensive attitude. When complaints and concerns had been raised, for example about the conduct of staff or meal options available, they were not dealt with in a transparent and timely way.
● Staff were concerned about potential repercussions from raising concerns with the registered manager. For example, a staff member told us, "The staff really care about the residents, but when we raise concerns nothing changes, and we are worried that we will get into trouble. I feel sorry for the residents."
● Another staff member told us, "Staff won't go to management about things anymore because what's the point, nothing will get done, or you get shouted at or put down in front of everyone. Residents also feel like they can't tell management things as they think they will get into trouble."
● The provider's complaints system was managed inconsistently, and concerns were not always recorded. The provider's records indicated one formal complaint had been received in the last 12 months, from a person who had previously lived in the care home. The complaint had been responded to by the registered manager, but there was no indication of any learning from the complaint being applied to practice within the care home.

End of life care and support
● People did not always receive kind and compassionate end of life care and support. For example, a person who returned to the care home from hospital, and who was believed by the registered manager to be close to the end of their life, had been moved from a larger bedroom which met their needs, into a smaller room which they did not like.
● The person told us, "This isn't a nice room, I liked my other room, but I have moved over the way to here. I don't like it here. It was better in my other room. I don't like it here I can tell you that. I'm too hemmed in here."
● The inspector raised this with the registered manager who told us the larger bedroom had been promised to another person and, as the person returning from hospital was not expected to live more than a few days, they felt it appropriate to move them into the smaller room. This did not demonstrate empathy towards the person.
● Subsequent to the discussion with the inspector, the registered manager arranged for an adjoining room to be used by the person as a day room, so they had more space and access to a television.
● The culture of the care home was not always supportive of people identified as being close to the end of their life. For example, a staff member told us a person regularly fell over when they walked, which led to bruising and minor injuries.
● There was no evidence the person had been referred to external healthcare professionals for advice on preventing falls. The staff member told us, "[Person] is on end of life anyway, so there isn't much we can do

about them." This view demonstrated the provider had allowed a culture of a lack of empathy and compassion to develop within the care home.

Inadequate

Is the service well-led?

Our findings

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

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; 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 did not have appropriate and effective systems in place to assess, monitor, and improve the service provided to people at the care home. For example, the issues found during this inspection had not been identified by the provider's own quality monitoring arrangements.
- The provider's quality monitoring process was limited and did not identify what improvements were needed, who was responsible for completing the actions, and the timescales for completion.
- The registered manager did not comply with regulatory requirements to safeguard people. For example, they had failed to notify the local authority and CQC about alleged verbal abuse at the care home.
- The registered manager had not complied with the Mental Capacity Act or DoLS requirements. This meant some people were living in the care home without those appropriate legal safeguards being in place.
- The provider did not always have an open and transparent approach. For example, the provider told us action had been taken to prevent people from altering the shower hot water temperature, as an interim measure to prevent scalding until a permanent safe solution was implemented. The provider told us they had secured the downstairs shower so that it could not be altered. We found that was not the case.
- The provider had unclear roles, responsibility, and accountability arrangements. For example, the registered manager also worked as a carer and cook at the care home. This meant the registered manager had limited ability to carry out their management tasks.
- The provider also employed a day manager and a deputy manager at the care home. However, due to ineffective delegation and unclear roles, it was not clear which tasks were being carried out by the registered manager and which by the other managers at the service.
- The provider used electronic care records which were not always accurate. Care plans were not always reviewed at the intervals identified by the provider's electronic record system. The provider's quality monitoring processes had not identified this as an issue.
- The provider had been repeatedly asked to send electronic copies of relevant documents and safety certificates etc to the inspector to review as part of this inspection process. The provider had failed to send copies of requested documents and had provided no explanation for this.

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

- The service had some of the characteristics of a closed culture. For example, several staff told us they did not feel able to be open when things went wrong, and that the reporting of incidents was discouraged by the

registered manager.
● The provider did not have an inclusive approach. For example, some staff told us they were not listened to by the registered manager and did not feel all staff were treated equally.
● The provider had not established a positive culture at the service. For example, the registered manager was aware that people, and staff, had raised repeated concerns about alleged bullying and verbal abuse by a staff member towards people. Appropriate action had not been taken and this created the impression among the staff team that such behaviour was tolerated.
● People were not always supported to achieve good outcomes from the service. For example, a person had made it very clear they did not want to continue to live at the care home, but no action had been taken by the provider to support the person to move to an alternative placement.
● The provider did not display their CQC rating for the care home at the premises. A regulated activity was being provided at the premises, and the service provider had been previously rated by CQC, this meant there was a requirement that the rating must be displayed at the care home.
● The inspector raised this with the registered manager on the first inspection site visit. However, on each subsequent site visit it was observed that the provider had still not displayed their existing CQC inspection rating.

The provider failed to have effective systems in place to assess, monitor, and improve the quality and safety of the services provided in the carrying on of the regulated activity. This was a breach of regulation 17 (1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People were not effectively engaged and involved by the provider in respect of obtaining their feedback on the service they received. Satisfaction surveys were not routinely carried out, and no action plan existed for improvements identified from feedback.
● Staff were not effectively engaged and involved by the provider in the running of the service. Staff meeting issues/discussions were not recorded and there was no evidence of the provider seeking regular feedback from staff about how the service might improve.
● For example, staff told us the provider did not take concerns they raised seriously and that this discouraged them from raising further concerns.

Continuous learning and improving care
● No evidence was seen that the provider understood the principles of good quality assurance. There was no overarching improvement action plan in place and no evidence the provider was driving ongoing improvements at the care home.
● Staff told us that when incidents occurred, they were discouraged from reporting them by the registered manager. When they did report them, they received no feedback from the registered manager about any actions being taken because of the incident.
● Opportunities to improve care were missed. Copies of incident records were not always available to be reviewed at the care home. This meant learning from incidents was not evidenced as having taken place.

Working in partnership with others
● The provider did not always work well in collaboration with other services. This increased the risk that people would experience poor or badly coordinated care.
● For example, an external professional told us, "The staff are responsive, but not the registered manager. The registered manager has previously stated to us that they think we interfere too much. But, for example, a person would have been left without effective pain relief if it wasn't for our team making sure they got the

prescription. That wouldn't have happened if it was left to the registered manager and the team there to sort out."

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 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure care and treatment was only provided with the consent of the relevant person.

The enforcement action we took:

We placed an urgent Condition on the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to adequately assess the risks to the health and safety of service users receiving care. They also failed to take action to mitigate any such risks as far as is reasonably practicable. The provider failed to ensure the proper and safe management of medicines. This placed people at increased risk of harm.

The enforcement action we took:

We placed an urgent Condition on the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider's systems and processes failed to safeguard people from the risk of abuse and improper treatment.

The enforcement action we took:

We placed an urgent Condition on the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider failed to maintain appropriate

	standards of hygiene and cleanliness. This placed people at increased risk of harm from health infections.

The enforcement action we took:

We placed an urgent Condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to have effective systems in place to assess, monitor, and improve the quality and safety of the services provided in the carrying on of the regulated activity.

The enforcement action we took:

We placed an urgent Condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to deploy enough staff to meet people's care needs. This placed people at increased risk of harm.

The enforcement action we took:

We placed an urgent Condition on the provider's registration