Leonard Cheshire Disability

Agate House - Care Home with Nursing Physical Disabilities

Inspection report

Woburn Street
Ampthill
Bedford
Bedfordshire
MK45 2HX

Tel: 01525403247
Website: www.leonardcheshire.org

Date of inspection visit:
18 October 2021
27 October 2021

Date of publication:
15 December 2021

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
Agate House is a 'care home' providing accommodation, personal and nursing care for up to 36 people with a physical disability. At the time of our inspection there were 33 people using the service.

Agate House Care Home provides all accommodation, communal areas and therapy support on ground floor level. The building is split into four separate wings, each of which has adapted facilities.

People's experience of using this service and what we found
People were at risk of dehydration, poor outcomes and skin damage due to ineffective monitoring methods and oversight by the provider. Medication processes were not always safe, and staff practice surrounding medical devices placed people at risk of harm. We notified the local authority safeguarding team of our concern for one person during the inspection process.

Safe staffing levels were not robustly assessed or reviewed to ensure people's needs were met in a timely manner. People, relatives and staff told us staffing levels were not adequate nor safe to meet the needs of people. Staff were not adequately supported nor supervised to ensure people's needs were met. Staff competency assessments were not completed in all instances to ensure safe care, and to identify training needs.

Staff had not completed training to meet the needs of all people. Staff did not always know how to confidently respond to people's changing needs and they lacked confidence in the provider's procedures.

People were not always treated with respect and dignity. Choices for people were limited, and a person-centred approach to care was not always evidenced. People's records were not stored in a secure and confidential manner in all instances. People, and their families, where appropriate, were not always involved in the ongoing care planning process.

People were not supported to raise concerns. The provider's complaints procedure was not known and available to people and relatives. Staff told us their views were not always sought, listened to, and acted upon. Furthermore, staff told us they did not always feel valued.

People did not receive emotional and social support which met their needs. People were not always supported with their methods of communication and we observed missed opportunities for communication during the inspection.

The provider's quality assurance and governance systems had not identified our findings and did not always drive continuous improvements. Safe person-centred practice was not evidenced on all occasions, nor embedded into service provision. We found oversight and processes relating to areas such as statutory notifications, complaints, safeguarding, medication management and incidents were not always effective.

People told us they felt safe and relatives told us regular staff were hard working and dedicated. People were supported with specialist diets and staff were aware of the recommended safe food and drink consistencies of people. The provider's representatives took some immediate actions during the inspection and told us they were committed to making the required improvements. For example, they sent us information which identified action had been taken to complete staff competencies, and source additional training.

People were not always 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.

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 18 November 2017). This service has deteriorated to Inadequate.

Why we inspected
We received concerns in relation to unsafe care, inadequate staffing levels, and poor leadership at the care home. We undertook a direct monitoring activity which did not provide us with assurances. A decision was made for us to inspect and examine those risks.

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

The overall rating for the service has changed from Good to Inadequate. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvements. 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 inspections, by selecting the 'all reports' link for Agate House on our website at www.cqc.org.uk.

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

We have identified breaches in relation to safe care and treatment, staffing, dignity and respect, person-centred care and good governance at this inspection.

We issued a warning notice to the provider in response to a breach of regulation 17 (good governance) and we have imposed a timescale for the required improvements to be completed.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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? The service was not 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 well-led. Details are in our well-led findings below.	**Inadequate**

Agate House - Care Home with Nursing Physical Disabilities

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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

Inspection team
This inspection was carried out by three inspectors.

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

The service did not have a manager registered with the Care Quality Commission in place at the time of our inspection. This means that the provider is legally responsible for how the service is run and for the quality and safety of care provided.

The provider had appointed a new manager who had begun the process of registration with the

Commission.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed the information we had received about the service since the last inspection. We sought feedback from the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

A direct monitoring activity took place prior to our visit and we gained feedback from two people who lived at the care home, three staff members, and three relatives. We also viewed a range of records which included a support plan for one person and governance records. We spoke with the regional support manager and the quality business partner; they will be referred to as the provider's representatives throughout this report. Additionally, we spoke with a deputy manager and a consultant nurse employed by the organisation.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with seven people who used the service about their experience of the care provided. We spoke with fourteen members of staff including the provider's representatives, a deputy manager, the organisations consultant nurse, one agency nurse, one team leader, care workers, an agency support worker, a maintenance worker and a housekeeper.

We reviewed a range of records at the service, this included recruitment documentation for two staff, agency staff proforma's and induction records. We also viewed medication records and care records for people. We asked the provider's representatives to send us a range of records so that we could review these away from the care home. Records included care plans, risk assessments, monitoring documentation, staff rotas and staff training and supervision records. Additionally, we requested some policies and other records relating to the management and oversight of the service.

After the inspection
Following the visit we reviewed the records which were sent to us as requested. We spoke to a further four relatives and four staff which included nurses and care workers. We also received feedback from one other person who used the service. We held a virtual call with the providers representatives, a deputy manager, the activities co-ordinator, a team leader and the new manager. We also spoke with two health care professionals who provided us with feedback on their experiences. We sought further clarification from the provider's representatives so we could confirm the accuracy of the records.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Using medicines safely

- People were at risk of dehydration and poor outcomes due to ineffective monitoring. Food and fluid records for three people were not appropriately completed, and responsive action was not evidenced for low recordings.
- People were at risk of skin damage. Mattress settings were not checked daily and re-positioning charts evidenced people were not assisted in line with their requirements. Four people's records provided varying guidance to staff; this had placed people at risk of not receiving consistent and appropriate care to meet their needs. One person told us if they did not use their call bell for positional support when it was due, they would not be assisted in good time.
- Risks were not assessed and reviewed to reflect the changing needs of people. One person's records stated they had a specialist air alternating mattress, we found they had a standard mattress. Another person's records stated they used a manual wheelchair, we found they used an electric wheelchair. One staff member told us all risk assessments required review and updating.
- People were at risk from fire. Automatic door closures were not fitted to all bedroom doors. The provider's representatives took immediate action to ensure this was rectified, however, their reviews had not identified this.
- People were at risk of harm due to ineffective processes and record keeping. One person's records identified they required specific care support two days prior to our visit, this had not taken place. Records did not provide clear guidance and insight regarding the risk to this person, what reviews and communication had taken place, and what follow-up action was planned.
- Medication oversight was not safe. Medication amounts did not correspond with medication administration electronic records. We checked medication for two people and no explanation was available as to why there were too many or too few tablets.
- Staff did not follow best practice and care assessments in all instances. We observed unsafe practice for one person which related to medication administration, medical device management and wound care practice. We notified the local authority safeguarding team of our concerns.

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

- Unexplained bruising was not always appropriately investigated and reported. Records for one person identified unexplained bruising, however, no investigative action took place until we requested this, which was seven days after the initial recording.
- Lessons were not always learnt. National patient safety alerts had been widely shared regarding the risk of asphyxiation to people who may incorrectly ingest thickening powder. Thickening powder is used to make drinks a safe consistency for people who have swallowing difficulties. We found people may be at risk of asphyxiation due to thickening powder being left unattended in a communal area.

We found systems were either not in place or robust enough to mitigate risks, where possible, to people's safety. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Despite our findings, people told us they felt safe. One person told us, "I feel really safe with the staff. We are fortunate to have some cracking staff here". Relatives told us their family member was safe and reflected on the safe environment the care home had provided during the COVID-19 pandemic.
● One person returned from hospital at the time of our visit. Staff arranged for the persons formal assessments and care plans to be updated to reflect their safety needs which included COVID-19 procedures. Staff undertook competency assessments for oxygen therapy, and we were told the fire risk assessment was reviewed and updated accordingly.
● Medication was appropriately stored. We observed suitable medicine support was provided to people by an agency nurse.
● Staff had received safeguarding training and told us of the types of abuse they may encounter.
● Safeguarding information was displayed at the care home which provided guidance to staff. This information included the contact details of the local authority and CQC.

Staffing and recruitment
● Safe staffing levels were not robustly assessed or reviewed which placed people at risk of harm. The provider's representatives told us they determined staffing levels using people's individual assessments. Overall staffing numbers were not calculated, and staffing levels were not formally reviewed.
● Staff told us it was not unusual to provide morning personal care to people during the late morning and sometimes past midday. People confirmed this, and one person reflected on a recent experience and told us, "I missed so much of the day". We found people waited for support with personal care; assistance with meals, and therapy exercises during the inspection.
● People, relatives and staff shared concerns regarding safe staffing levels and told us staffing had decreased over time without explanation. People and staff told us this had impacted on support availability and staff said, "We are exhausted, we just don't have the time to spend with people". Our observations confirmed this, we found staff engagement with people was often task based with little time available for social support. The provider's representatives told us there had been a review of staffing, and staffing numbers had been decreased in recent months following a formal review. Records relating to how calculations took place were not available upon our request.

Robust systems were not in place to calculate and review staffing requirements at the care home to ensure there were sufficient staff to meet people's needs. This was a breach of regulation 18(1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

● We were assured the provider was facilitating visits for people living in the home in accordance with the current 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 the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Staff supervision and annual appraisal had not taken place in line with the provider's policy. Staff told us supervisions were intermittent and long periods of time could elapse. Records reviewed confirmed this. Competency assessments had not been completed in all instances which placed people at risk of receiving ineffective care from staff.
- Staff had not received training to fully understand and respond to the support needs of people. Staff told us they did not always know how to confidently respond to specific events, such as marks and bruising, or epileptic seizures. Staff had not received training in support areas for people, such as epilepsy, skin integrity, diabetes and end of life care.
- Agency staff were utilised at the care home and induction records were evidenced. People, staff and relatives shared concerns relating to communication and language barriers and told us agency staff were not always familiar with the support needs of people. We were told agency staff would be left for periods of time without the support and knowledge of regular staff. At the time of inspection, we observed agency staff working for periods alone and shared our concerns with the provider's representatives.

We found robust systems were not in place to ensure staff support, training, skill and experience. This placed people at risk of harm. This was a breach of regulation 18(2) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People were encouraged and supported to be part of future recruitment for prospective staff.
- Staff told us although supervision was infrequent, when it did take place, they found it a supportive process, and welcomed it.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to eat and drink enough to maintain a balanced diet

- People were not always supported in line with evidenced based guidance. We observed practice, and reviewed documents, which did not always promote the wellbeing of people.
- Records contained conflicting information which did not evidence detailed reviews took place by staff. Staff told us they did not have time to read care plans and were not always aware of risk reducing measures for people.
- People were not always enabled to make meal choices and were not aware of daily menus. We saw a menu which identified a limited option of a main meal or a vegetarian alternative.
- People, staff and relatives told us food provision could be improved for more varied options, less frozen

food and more fresh fruit and vegetables. Our findings also confirmed this. One person told us, "The food is not the greatest, it is edible, and you can survive on it".
● Staff were knowledgeable of the assessed safe food and drink consistencies for people. However, one person was offered a specific desert by staff and was then told, "Oh no, you can't have that can you".

Adapting service, design, decoration to meet people's needs
● People were not always consulted regarding the care home environment. People told us improvements would be welcome to outside spaces and internal areas needed remedial work and decoration.
● One person's bedroom required attention due to wheelchair damage to walls, and general wear. Since the inspection the provider's representatives informed us this room was redecorated with the person's involvement and they had chosen the colour scheme.
● The provider's representatives evidenced an internal decoration review had been completed, and plans were underway for scheduled redecoration.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
● Staff were not always confident in the principles of the MCA but did evidence the importance of the involvement of people with care decisions. However, opportunities were not available to people to make daily choices in relation to meal options and activities.
● People's capacity to consent to their care and treatment had been considered and was documented appropriately. Suitable assessments had been made where people lacked capacity to make certain decisions and staff were aware of these.
● A log was in place which monitored DoLS authorisations. The log identified where applications and renewals took place, and evidence was available of follow-up enquiries. The provider's representatives were aware of the status of authorisations at the care home which evidenced oversight and monitoring processes in the best interests of people.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People were supported to attend healthcare appointments, and healthcare professionals visited the care home where it was appropriate for them to do so.
● Referral processes were in place, and effective reviews were completed when required for healthcare professional involvement.
● Healthcare professionals told us staff were familiar with the needs of the people and assist with review

processes.

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 the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care

- People's privacy and dignity was not always a priority promoted in practice. Staff did not always consider the most appropriate and respectful place to provide care and support to people. We observed unsuitable nursing support being provided to one person in a communal room which did not uphold their rights.
- Staff did not always provide personalised support and reassurance. We observed two people coughing during mealtime and staff asked one person if they were "Okay" with no further reassurance or review. Staff held a tissue to another person's mouth, with no further interaction. People were not always provided with prior communication and reassurance before being moved in their wheelchairs.
- Individualised communication methods of people were not always recognised. One person was assisted with their meal and expressed using body language they did not want any more. Agency staff did not recognise this and offered little interaction with the person.
- People told us they often faced communication barriers with agency staff due to time, language and their individualised methods of communication not being known. People told us this led to miscommunication and frustrations.
- Records were not always stored securely. We found people's personal records were freely accessible in corridors. The deputy manager told us these had been left out by staff, despite requests for this not to happen.
- People did not know when they would be receiving specific therapy support and told us limited staff availability often caused this.

We found robust systems and observational checks were not in place to protect the rights of people. This placed people at risk of not receiving respectful and dignified care. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Despite our findings and observations, people and relatives told us that regular staff were caring, hardworking and dedicated to their roles. One relative told us, "They [staff] are genuinely caring and welcoming. They are wonderful".
- One person told us, "The staff always ask me how I'm getting on and respect my wishes".
- The provider's representatives told us they were dedicated to obtaining consistent agency staff bookings to assist with continuity and familiarity for people.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated 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; 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 not aware of their care plans. Relatives, where appropriate, told us they were not regularly updated in relation to health reviews, appointments and the care needs of their family member. We reviewed records for one person and their care plan review did not evidence involvement for 17 months.
- Allocated time to review care plans with people and relatives was not embedded at the care home. Staff told us they gained feedback from people relating to their care needs, however, time was limited. One person told us, "No one ever comes and asks me how it is going, or how I am getting on".
- Positive outcomes for people were not always available. One person's care plan said they should have choice available, but no daily meal or activity choices were given to them. Another person's care plan said they should have social involvement and positive interactions with people and staff, they told us this did not happen.
- Planned activities were not always available for people. People did not know what activities were available to them at the time of our visit. Daily records for people were task based and offered little insight into people's mood and general wellbeing.
- People told us they wanted more involvement and interaction with staff, and they sometimes experienced long periods without engagement. We observed this at the time of inspection.
- Activities staff were employed at the care home; however, staffing provision was not adequate to meet the diverse needs of people. At the time of our visit there was one staff member providing activity support to 12 people, and people did not all appear engaged. A voice-controlled device was used for a quiz, this was not inclusive and did not consider the needs of all people. The second activity was planning for a Halloween party. There were no activities available in the afternoon, and we found many people returned to their bedrooms with little interaction available.
- We found care plans were written in a person-centred manner, but it was unclear how personal plans transpired into good outcomes for people.

Meeting people's communication needs

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

- The provider had pictorial and easy read versions of procedures, such as complaints. However, these were not freely available to people at the time of inspection.

● There were missed opportunities to provide individualised information to people. There were no menu's or activity planners, in written or pictorial format, available for people to make informed choices.
● People were not always given time to communicate using their preferred method with assistive technology. One relative told us their repeated requests for their family member to have specific technology available to them had not been listened to on all occasions.

We found people were not always being supported in a person-centred manner. People were not engaged throughout the day, and people's individual likes; dislikes and preferences had not been sought nor considered in all instances. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Despite our findings, people did experience elements of personalised care which supported their interests.

● Peoples bedrooms were personalised with belongings, such as family photos and sport memorabilia.
● People were supported with cultural and spiritual needs. Staff ensured contact was maintained with ministers of faith throughout the pandemic.
● People were not all able to physically attend an event of importance to them. The activities coordinator planned for a live video link to take place, so people were able to feel part of the occasion at the care home. This had evidenced an inclusive approach to care and support for people.
● Relatives told us staff had supported their family members to attend specific family celebrations and occasions. People had been supported to attend events in the community and volunteers were matched with people based upon interests, such as chess.
● Events had been organised by the activities team. These had included a 'beach day', which brought the seaside to the care home with a visiting ice-cream van in attendance. Social evenings and themed events had also been planned and taken place.

Improving care quality in response to complaints or concerns
● People and relatives were not always aware of how to raise a complaint, and effective systems were not in place to ensure the feelings of people were shared and acted upon.
● One person had shared their dissatisfaction of support with staff and requested their comments be shared with management. This person's feelings had not been reviewed or acknowledged for 15 days until our request for their records.
● The provider had a complaints procedure with an easy read format to meet the communication needs of people.

End of life care and support
● At the time of our inspection no person was in receipt of end of life care.
● Future wishes of people had been sought to ensure their choices and views were gained as part of the care planning process. Healthcare professional involvement was evidenced where appropriate.

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 the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The findings of this inspection did not always evidence good outcomes for people. People were not supported in line with their assessed needs, and appropriate reviews of staffing levels had not taken place.
- The provider's quality assurance and governance systems were either ineffective or not in place. They had not identified our findings, nor did they always drive continuous improvement.
- Oversight, analysis and procedures required development in many areas. Systems were not clear nor embedded into practice to promote safe and person centred care. We found improvements were needed in many areas, which included: complaints, accidents and incidents, safeguarding and medication management. People did not have choice in all areas of their life, and the experience for people did not evidence an open and positive culture at the care home.
- The provider had not effectively monitored recruitment procedures. Gaps in employment had not always been explored prior to the appointment of staff.
- Ineffective monitoring, in relation to safe food hygiene practices and the use of enhanced PPE had placed people at risk of harm. The provider's representatives took immediate action to rectify these concerns, however, this was done in response to our findings.
- We found breaches of regulation relating to safe care and treatment; staffing; privacy and dignity; person-centred care and good governance. These widespread failings did not demonstrate the providers understanding of regulatory requirements for the safe care of people.

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

- People, relatives and staff had not been approached for feedback and insight of the service provided, and communication opportunities were not always available.
- Regular supervision and meeting opportunities were not provided to staff. Development plans required review, and additional learning and support needs of staff had not been identified.
- Staff told us they did not always feel valued, and their concerns were not always listened to and acted upon.

The provider had failed to consistently assess, monitor and mitigate risks to people's health, safety and welfare. The provider had failed to improve the quality of the service. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's representatives responded to our findings throughout the inspection process. We were told meeting opportunities had been organised for people, relatives and staff, and systems and processes were under review. The provider's representatives told us they were committed to making the required improvements and organised for a service improvement meeting to take place.

● The provider had appointed a new manager since our last inspection, and it was their first day in post at the time of our visit. The manager began the registered manager application process with CQC during the inspection period.

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 had failed to notify us of all significant events which occurred at the service. These notifications enable us to monitor the service and any actions taken. However, statutory notifications were promptly submitted in retrospect, and additional notifications were submitted when required for subsequent reportable incidents following our inspection.

● Two relatives told us of an occasion where they had received positive contact and acknowledgement when things went wrong. We were told communication was open and honest with actions taken shared.

● The provider's representatives were aware of their responsibilities to be open and transparent. Throughout the inspection process we noted that our findings were reviewed, acknowledged and several areas were acted upon without delay.

Working in partnership with others

● Professional teams told us their request for records had not always been acted upon in a timely manner. Prior to this inspection visit, this had also been our experience. However, during the inspection process records were provided to us within an agreed timescale.

● We received feedback from healthcare professionals who provided support to people and the staff at Agate House. We were told that staff were proactive in their approach to referrals, and additional support and training was available to staff where required.

● A recent trial took place for a new clinical system to be available within the care home. With the support of clinical teams, this system would allow for prompt clinical assessment of people should their health decline or should staff become concerned for their wellbeing.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not always being supported in a person-centred manner. People and relatives, where appropriate, were not always involved in the care planning process. People's individual likes; dislikes and preferences were not sought nor considered in all instances. Daily choices were limited, and people were not always supported to communicate and share their feelings for appropriate action and review to take place. Regulation 9 (1) (a) (b) (c) (3) (a) (b) (c) (d) (e) (f) (g) (i)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect, and this was not a priority promoted in practice. Management systems and observational checks were not effective to protect the rights of people. Regulation 10 (1) (2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were at risk due to ineffective processes and systems for fluid balance monitoring; the promotion of skin integrity; medication and

	medical device management. Safety risks relating to thickening powder storage was not always followed, and risks relating to fire safety had not always been assessed. Risk assessments and care records did not always reflect the current needs of people to mitigate risks where possible. Unexplained bruising was not always appropriately recorded and reported. Regulation 12 (1) (2) (a) (b) (c) (d) (g)

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 People who used the service were not protected against risks associated with safe staffing levels. Staffing levels were not robustly assessed or reviewed, and people experienced delays to their care. Staff had not received training to meet the specific needs of people, and staff supervision and appraisal had not been completed in line with the providers policy. Regulation 18 (1) (2) (a)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not effective in identifying, monitoring and improving quality of care and safety. Risks were not identified, assessed and mitigated in all cases. People and their relatives had not always been involved in the care planning process nor approached for feedback in relation to the service provided. Staff supervision and training needs had not been assessed in all instances and competency checks were not up to date. We found multiple breaches of regulations relating to safe care and treatment; privacy and dignity; person-centred care and good governance. Regulation 17 (1) (2) (a) (b) (c) (d) (e) (f)

The enforcement action we took:

We served a warning notice on the provider which required them to make the necessary improvements by 11 February 2022.