Priory Mews Healthcare Limited

Priory Mews Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Priory Mews Care Home is registered to provide personal and nursing care to up to 156 people. At the time of the inspection 112 people were living at the service. Priory Mews Care Home is purpose built and arranged across five separate buildings (referred to as units in this report). Cressenor and Mountenay have capacity for 42 and 30 people respectively and provide nursing care for people living with dementia. Beaumont has capacity for 30 people and provides general nursing care. Marchall has capacity for 23 people and provides residential care for people living with dementia. Berkeley has capacity for 15 people and provides general residential care for older people. A separate building houses the management and administration offices, kitchen, reception and training facilities.

People's experience of using this service and what we found
People were not protected from harm. Staff did not always recognise what constituted abuse. Individual risks were not always assessed appropriately, and safe measures were not in place to manage and mitigate risk. Medicines were not managed safely. Incidents were not always reported to enable close monitoring and learning lessons to achieve better outcomes.

Although agency staff were used to cover shortfalls in staffing levels, staff were not sufficiently deployed across the service to ensure people's needs were met. Safe and robust recruitment practices were not followed.

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

People's needs were not always assessed accurately or kept up to date to make sure people received safe and appropriate care. Staff supporting people received training but did not always put this onto practice, so people's safety was compromised. Healthcare advice was not always followed, putting people at risk of deterioration in their health. People were happy with the choice of food, but some people were not supported to eat their meal in a safe or comfortable way.

The environment was poor in some areas. Some bathrooms were cluttered and unclean with items in easy reach that could be unsafe for people walking around. The service was not clean in all areas and some doors were broken and therefore a hazard.

People were not supported to maintain their privacy and dignity. People were calling out and staff were not attending to them quickly to provide reassurance. Many people were cared for in bed without evidence of a valid reason.

Some people were not supported in a person-centred way with their individual needs and wishes driving

their care. Some people were not supported to have a meaningful day that prevented social isolation. Complaints were not always reported or logged in order to monitor and learn lessons.

The provider had taken over the service on 30 August 2022 and told us they were working hard to make improvements, including refurbishing people's living environment, staff recruitment, staff training, creating a positive staff culture and to increase meaningful activity. However, we saw poor care, relatives told us about poor care and parts of the living environment were not safe or pleasant to live in. Most of our concerns had not been identified and recognised by the provider or registered manager through monitoring and auditing processes.

Information was not always accessible and people's communication needs were not always met, to make sure people understood. We have made a recommendation about this.

We had better feedback from relatives of people living in some units than others.

People could have visitors at any time without restriction.

People had end of life care plans in place. The provider and registered manager had held meetings with people, relatives and staff since taking over the service. The provider had also undertaken satisfaction surveys with people, relatives and staff.

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

Rating at last inspection
This service was registered with us as a new provider on 30 August 2022 and this is the first inspection.
The last rating for the service under the previous provider was good, published on 27 January 2021.

Why we inspected
The inspection was prompted due to concerns received about people's safety, dignity and respect, staffing and management and leadership. A decision was made for us to inspect and examine those risks.

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

Enforcement and Recommendations
We have identified breaches in relation to safeguarding vulnerable adults, management of risk and learning lessons, medicines management, staffing, recruitment, people's rights under the MCA, person centred care, dignity and respect, complaints and management and leadership at this inspection. We have made a recommendation about accessible information and communication.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.
Please see the action we have told the provider to take at the end of this report for some of the identified breaches.

Follow up
We will request an action plan as well as 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service is 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 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.

Priory Mews Care Home

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was carried out by 2 inspectors, 2 medicines inspectors and 1 specialist advisor nurse on 22 February 2023 and by 2 inspectors on 23 February 2023. An Expert by Experience made telephone calls to people's relatives on 24 February 2023. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

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

At the time of our inspection there was a registered manager in post. However, the registered manager was not present during the inspection.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since it was registered with us. We sought feedback from the local authority including their safeguarding team and commissioners, professionals who work with the service and the local Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.
We used all this information to plan our inspection.

During the inspection
We spoke with 6 people who used the service and 12 relatives about their experience of the care provided. We observed the care provided within the communal areas. We spoke with 27 members of staff including the nominated individual, a director, operations and compliance manager, head of care, compliance officer, unit managers, deputy unit managers, senior care workers, care workers, activities co-ordinators, domestic staff. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included 14 people's care records and multiple medication records. We looked at 6 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including auditing and monitoring records and policies and procedures were reviewed.

Inadequate

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management

● Individual risks were not always assessed or plans in place to mitigate and prevent harm. Many people were cared for in bed. This created a greater risk of choking when eating their meals and snacks. The risks had not always been fully identified and robust guidance was not in place for staff to follow. Some people's risk assessment recorded they were to sit up when eating in bed and staff to monitor. The guidance did not state what this meant for the individual, such as should staff stay with them when eating, or how often staff should check on them. We saw people eating their food while lying down in bed. There was no guidance in their care records to say if it was the person's choice and how to mitigate the risk of choking.

● Some people became agitated and frustrated which could result in them being a risk to themselves or others. The guidance in place was not sufficient to enable staff to provide people with positive consistent support to reduce distress, de-escalate the situation and reduce further incidents. We saw people becoming distressed during the inspection and witnessed incidents of agitation and frustration between people. Staff walked away from the situation during some of these incidents. The lack of appropriate guidance around people's heightened distress and aggression meant people were at increased risk of harm.

● Some people had a catheter. There was no guidance in place to inform staff how best to care for the catheter, for instance, how often to change the bag, clean the site or how to spot signs of infection. Staff's documentation of fluid input and output was inconsistent. There was no evidence that records were reviewed to quickly identify concerns, such as ensuring the catheter was draining correctly, in order to seek medical advice quickly.

● Staff handed over to each other between shifts. A handover sheet was used for this purpose. The information on the handover sheet did not always accurately describe people's care needs. For example, the handover sheet stated one person was continent, when they were actually incontinent, and stated another person was on a normal diet when they should have been on a diabetic diet. This meant people may be at risk of not receiving appropriate or safe care. The high numbers of agency staff on shift increased the risk as they did not have the knowledge of people that permanent staff would.

● People's risk assessments did not always have up to date information in relation to individual risks. One person had fallen a number of times, 3 times in 3 weeks. At the time of the inspection, they had bruising and skin tears as a result of a fall. There was no mention of falls in their moving and handling risk assessment. Their falls risk assessment and falls reduction plan stated they had no history of falls. This placed the person at greater risk of falls as an accurate plan was not in place to reduce falls.

● Risks to the environment had not been properly assessed; bathrooms which were accessible to people contained disposable and electric razors, toiletries and people's prescribed creams, which could pose a risk to people. Radiators, including those in people's bedrooms, communal areas and bathrooms were unguarded and no risk assessments were in place. This presented a risk of significant burns should a person be in contact with a hot surface for too long. For example, if they were unresponsive or lacked the mobility

or cognitive capacity to move away from hot surfaces. The provider assured us they would rectify this straight away.

The provider and registered manager failed to assess and monitor the risks to the health and safety of people or do all that was reasonably practicable to mitigate risks. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. Not all areas of the service were clean. Some areas had broken doors and chipped wood and paint which could pose an infection control risk.

● We were not assured that the provider was supporting people living at the service to minimise the spread of infection. People who needed to use a hoist to move around did not have access to their own sling. Hoist slings that were shared were not washed in between uses between people. This increased the risk of infection. We spoke to the provider about this who said they would rectify the situation.

The provider and registered manager failed to assess and monitor the risks to the health and safety of people or do all that was reasonably practicable to mitigate risks. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Learning lessons when things go wrong

● Lessons were not always learnt from incidents that happened. Accident forms were completed when people had falls or for example if someone sustained a skin tear. When these happened, action was taken to address the risk, including post fall observations and referrals to the falls clinic.

● However, staff were not documenting incidents of distress or physical aggression between people or people and staff. One staff member told us a person had punched them during an incident of distress. Another staff member told us they had locked themselves in the office when a person became very distressed. Neither incident had been logged, and therefore no review or learning from the incidents could be documented.

● Incidents between people had also not always been documented on an incident form. For example, the safeguarding folder stated that 1 person had harmed another, however there was no incident form to detail what action had been taken to try to reduce the risk of the incident re-occurring. We identified at least 3 incidents where people had been physically assaulted by another person which had not been documented. One person's care plan detailed that the GP had checked on them following an incident. There was no incident report to confirm what had occurred during the incident, or any learning as a result.

● ABC records were used to describe incidents of high anxiety and frustration. ABC records are used to learn from incidents to support better planning and outcomes for people. However, ABC charts were not always completed and were not used to monitor incidents in order to update people's care plans and risk assessments. One person displayed high levels of anxiety and would cry out for help. However, their records showed that only on 2 occasions an ABC chart had been completed. Staff we spoke with told us that the

person became distressed and shouted "daily" and that it was "usual" for them. We had similar conversations with staff about other people who had regular altercations with other people. No ABC charts or incident forms had been completed in the last week for 1 person, even though we witnessed an incident and were told this was a regular occurrence.

The provider and registered manager failed to assess and monitor the risks to the health and safety of people or do all that was reasonably practicable to mitigate risks. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some staff were more skilled than others when supporting people. We saw some staff members using good skills with a person who was demonstrating distressed behaviour.

Using medicines safely

● People were not always receiving their medicines as prescribed. Staff were not always administering medicines at the times they were prescribed, or recording the reasons why if they had not administered a medicine. Staff were crushing a medicine before giving it to one person. However, the pharmaceutical guidance for the medicine clearly states it must not be crushed.

● The service was not performing quality assurance check for its blood glucose diagnostic equipment for diabetic care management. This meant staff could not be assured the equipment was recording people's blood glucose levels accurately. People's diabetic care plans, where they were in place, did not contain any information relating to what their blood sugar levels should be, to maintain their health. Staff were not following instructions from the GP regarding 1 person's blood glucose testing and recording. We could not be assured peoples diabetic care was being managed safely.

● Covert medicines were not well managed. This means people at risk of refusing essential medicines may be given their medicines in food or drink with agreement of relevant healthcare professionals. Staff were not always aware of who was prescribed covert medicines or how to give the medicines correctly. Documents such as best interest decisions and advice on how to give the medicines was sometimes in place but it was not always correctly completed or regularly reviewed.

● Medicines were not always stored securely. Non-medicines trained staff could access the medicines keys in 1 unit. On 1 unit the recommended maximum fridge temperature had been recorded as too high for a number of weeks, but this had not been reported. This meant the efficacy of the medicines stored could be compromised.

● Medicines care plans were in place however, they did not always contain information about how to manage high risk medicines to keep people safe. PRN protocols for when required medicines had been completed for most medicines however, they were not always in place for medicines used to support people experiencing anxiety or agitation.

The provider and registered manager failed to manage medicines safely. This is a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● There were not always sufficient staff to meet people's needs. The provider did have a high number of staff vacancies and used agency staff to cover the gaps. The provider told us they had increased staffing levels since taking over the service. However, the deployment of suitably skilled and trained staff was not sufficient to meet people's very high and complex needs in 2 units. Relatives told us there were not enough staff, particularly at weekends. One relative said, "There was 1 permanent staff member and 8 or 9 agency staff on 2 Sundays recently. There is usually more agency staff than permanent staff." A nurse told us, "There are lots

of agency use – who are good, but they don't know people the same and not as well trained."
● Staff administering the morning medicines did not finish until 12.40pm on one unit and 11.30am on another unit. Some people did not receive their morning personal care until lunchtime. Staff told us this was usual due to people's high needs and the numbers of staff available. Staff gave examples of people who needed more 1:1 time but this was not available. We saw people calling out for help in their bedrooms and staff not attending to them.
● One person who was at very high risk of falls and had a sensor mat beside their bed. During the inspection, they had got out of bed and the mat alarm was sounding for over 10 minutes and no staff attended. As no staff were in the vicinity, we guided the person back to bed as they were unsteady. The person's care plan stated they could walk with a frame with the support of 2 staff. We saw them walking supported by 1 staff, not 2, but also saw them mobilising alone. Sufficient staff were not available to monitor the person closely to make sure they were safe.

The provider and registered manager failed to deploy staff appropriately and safely. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Safe and robust recruitment processes were not being followed. There were gaps in employment that had not been accounted for. Employment references did not tally with the information given by applicants about their past employment. Employment references had not always been verified, to provide assurance the references were from who they said they were from. Many references were typed with no signature or company stamp, and in some instances, who the previous employer was.
● Some staff had restrictions on their visas to work in the UK, such as the number of hours a week they were permitted to work. A mechanism was not in place to ensure restrictions were monitored. Some staff had worked more hours than their visa stated in the week before and the week of the inspection.

The provider and registered manager failed to have safe and robust recruitment processes in place. This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● People were not always safeguarded from the risk of abuse. Staff had training, and staff we spoke with were able to speak about the different types of abuse and describe how and where to escalate concerns. However, incidents had not been reported either to the provider or the local authority.
● One person was distressed, shouting and asking for help to get out of bed. Staff told us they did not get the person out of bed as they were at risk of falls and may try to get out of a chair and fall. The person was left alone, calling out throughout the day. Staff had not considered they were restricting the person by not supporting them to get out of bed. The person had been referred to the mental health team for support, however staff had not followed the guidance given. Advice included providing regular reassurance and one to one engagement and to refer the person back to the team if they continued to display high levels of distress.
● A relative had reported that their loved one's newly bought clothes had been taken from their wardrobe before they had a chance to wear them. Although the unit manager was aware, and stated they had no other explanation than a member of staff taking the clothes, they had not reported this to the police or as a safeguarding concern.
● A safeguarding folder was in place, which collated information of concern, and had an opportunity for learning to be documented. However, we identified that often the learning would be the same for each incident. For example, to 'stay vigilant' and 'look for triggers', there was no information provided on what these could be, if care plans had been updated or how this information was shared with staff.

The provider and registered manager failed to protect people from abuse and improper treatment. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

● Disclosure and Barring Service (DBS) checks were carried out. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Visiting in care homes
People's loved ones and friends could visit when they wished. Relatives told us there were no restrictions on visiting. Some relatives spent long periods of the day with their loved ones.

Inadequate

Is the service effective?

Our findings

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

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

Staff support: induction, training, skills and experience

- Staff did not always have the skills and experience to meet people's needs. Staff had access to training. The provider had employed an in-house trainer who had developed an induction for all new starters. Induction and subsequent refresher training was provided face to face. Staff were also expected to complete supplementary online training. Staff spoke highly of the training and said this had improved with the new provider.
- However, despite completing training, we found that some staff were not putting their training into practice, or had not fully understood or felt confident in their role. Some staff were not confident in supporting people living with dementia who were experiencing episodes of distress. We saw 3 separate permanent staff on 1 unit who were trying to support people to stand up from their chairs. All 3 staff gave up and walked away from each situation, asking another member of staff what they should do.
- We saw a member of staff supporting a person to transfer from their wheelchair to a chair using an unsafe technique even though they had recently received moving and handling training. Some staff were moving people in wheelchairs to other parts of the service, with their feet not correctly positioned, causing a risk of damage to the feet. There were issues around how some staff administered people's medicines unsafely, even though they had received training.

The provider and registered manager failed to ensure staff were appropriately skilled. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- People were not always supported to eat and drink safely or with appropriate support. Care plans were not specific about people's needs. Many people were supported in bed and so also ate their meals in bed. Their care plans did not always detail how to support them in the safest way while taking into account their preferences.
- One person was lying flat in bed while eating their meal. A staff member told us the person preferred this and would not eat the meal if staff sat them up. A risk assessment was not in place to provide guidance to staff what action to take to mitigate the risk of choking or other health issues as a result.
- A relative told us staff often forgot to sit their loved one up while they were eating. They said, "This is why I come in at lunchtime, every day I tell them the same thing. I know they don't sit him up." Another relative told us that when they visited their loved one, their drink was usually out of reach for them.
- We observed people with food in front of them for long periods of time. One staff member told us people needed prompting from staff to ensure they ate sufficient amounts; however, they did not always have time for this.

● One person's care plan recorded they often declined their meal, or were asleep at mealtimes. It went on to say staff should offer snacks. The care plan did not give any further guidance for staff to ensure the person was offered a healthy balanced diet, such as to keep their meal or to try a different time of day for a main meal.

The provider and registered manager failed to assess and monitor the risks to the health and safety of people or do all that was reasonably practicable to mitigate risks. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us the food was good. There were mixed views from relatives about food, some said it was good and others said it wasn't. One relative said, "I haven't seen it, but she likes it, and she eats everything, they get a good choice. She is putting on weight she lost when she was ill" and another told us, "Dry, bland, and repetitive, it doesn't seem to have much in the way of nutritional value. She often gets sandwiches, and she has told them she hates sandwiches."

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

● The provider had taken over the service in August 2022 and said they had a plan in place for refurbishment. They had re-decorated some units and were in the process of re-decorating others at the time of the inspection.

● However, 2 units were still in a poor condition. One door had a large part missing with open wood, which could pose a risk to people injuring themselves. There were holes in several rooms which had not been mended and made good.

● A number of bathrooms were being used to store equipment, with hoists, discarded hoist slings, incontinent pads and boxes. The bathrooms and equipment kept in them were not clean and staff would not have been able to use them to support people to bath.

● Room doors on some units were painted in different colours to support people living with dementia to find their room, other units did not. There was no other dementia friendly signage or adaption to support people who could become disorientated in some units.

The provider and registered manager failed to assess and monitor the risks to the health and safety of people or do all that was reasonably practicable to mitigate risks. This is a breach of Regulation 12 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 needs were not always regularly or accurately assessed. People had an assessment before moving into Priory Mews Care Home. Some assessments were completed well but some were not fully completed to provide a detailed account of people's needs to enable a care plan to be developed. Some assessments were not signed and dated by the person completing the document.

● Ongoing assessment tools, used to identify the care and support people needed to meet their needs and prevent a deterioration in their health, were in place but not always fully completed. These included tools completed monthly to assess people's risk of acquiring pressure sores or of malnutrition. Some questions were not answered which could give an inaccurate score. Scores were not added up correctly some months and this had not been picked up. This meant risks may not be calculated correctly to enable safe management plans to be put in place.

● One person's pressure area assessment tool showed they were at very high risk. However, the tool had not been completed since December 2022 and had not been fully completed, placing them at higher risk.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● People were referred to healthcare professionals to make sure they received the appropriate advice and treatment. For example, people had been referred to dieticians, tissue viability nurses (TVN's) and mental health teams. GP's visited some units regularly each week and made calls to other units.
● However, staff did not always follow the advice given. These included the treatment of one person's diabetes which placed them at risk of harm. The GP had advised staff to offer the person food late at night to try to control their blood sugar through the night and prevent a low blood sugar. There was no evidence this had happened. Staff could not confirm the person was given food as advised.
● Each person had an oral health plan; however, it was not clear that people were receiving oral care. A relative told us that their loved one's tongue was very discoloured. They told us they had purchased a tube of toothpaste which had still not been used since moving in. Their toothbrush looked untouched, and their daily notes did not note that their teeth had been cleaned.

The provider and registered manager failed to provide appropriate support in a person-centred way. This was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● Some people had wounds that had developed prior to being admitted to the service. Where this was the case, they had wound care plans in place, and the relevant healthcare professionals such as the TVNs were involved in their care.
● Relatives told us they were happy with their loved one's health care and confirmed that staff contacted healthcare professionals when needed. One relative said, "When he had a fall, they checked him over and then sent him for x rays at the hospital, but he hadn't broken anything", and another said, "Yes, they have called the doctor when she had a chest infection."

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.

● People were not supported in the least restrictive way possible and there was little evidence to show their rights were being maintained under the MCA. There was a lack of understanding of how to care for people who lack capacity in a way that upholds their dignity and legal rights.
● Many people were cared for in bed. Staff told us this was because they did not have enough staff to get people up as some people were at risk of falls. Some relatives told us their loved one was often left in bed, and they were unsure why. They were worried their loved ones would lose mobility.
● People's care plans did not record the reasons why people were cared for in bed. Mental capacity assessments had not been completed for people who were kept in bed because they were at risk of falls, to determine their capacity to consent to this. Restrictions were placed on people without consent and careful care planning.

● Mental capacity assessments had been completed where people were thought to lack capacity. However, these lacked the detail needed and were not decision specific. Appropriate best interest decision making processes had not been followed. For example, one staff member had completed the capacity assessment for one decision and had alone made the decision in the person's best interest. People's relatives or advocates or other appropriate people had not been consulted with.

The provider and registered manager failed to ensure people's rights were maintained and upheld. This was a breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● Applications for DoLS had been made appropriately and these were kept under review.

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.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

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

- People were not always treated with kindness and compassion. The high numbers of agency staff on some units meant although the numbers of staff available may appear sufficient, the deployment of staff who knew people well impacted on the care received.
- Some people in their bedrooms were calling out through the day. Staff did not respond by going in to them to have a chat and reassure them. Staff told us some people called out regularly.
- A relative told us their loved one was not always treated with kindness. For example, if staff moved their loved one to be more comfortable, staff did not always speak with them before, or whilst moving them. The relative told us, "They don't speak to him as they move him up the bed, I have to do that. He is a person. It's sad, it's thoughtlessness, not considering him as a person." Another relative said, "They aren't chatty or caring, they do what they have to do, turn around and walk out."
- People were not always treated with dignity and respect. People were in bed with their bedroom doors open, with no covers over them, exposing them to anyone walking past. Staff were still completing the morning personal care round until lunchtime, so some people were in this position for some time.
- Some people looked unkempt, with hair unbrushed and unshaven. A relative told us that sometimes when they visited their loved one they would be in the same clothes for 2-3 days.
- People or their loved ones were not always involved in decisions about their care. Decisions had been made in people's best interest without evidence these had been discussed with relatives. Reviews of people's care did not always involve the person or their loved ones to make sure care met their needs and wishes.

The provider and registered manager failed to ensure care was provided in a caring and dignified way. This is a breach of Regulation 10 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

- We had mixed views from relatives, which was dependent on the unit their loved one was living in. We had more negative views from relatives whose loved ones lived in 2 units where we found many concerns.
- Comments from relatives in the other units when we asked if their loved one was treated with dignity and respect included, "Yes, he is, they don't talk to you about someone else he is definitely treated with care and dignity" and, "Yes, they do they are kind when they come in, I don't know if they pop in when I am not there, yes, I think they do. They are very busy, but they do say they will pop in."
- We did see some nice interactions between staff and people. Some staff told us they were passionate

about their work and loved working at Priory Mews Care Home.

Inadequate

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated 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

- Some people did not always receive care that was personal and individual. Care plans were basic and did not provide the detail needed to make sure all staff had the guidance to understand people's needs and wishes. For example, 1 person's care plan referred to them by the wrong name, and detailed that their spouse had visited, when their spouse had sadly passed away.
- We saw 2 male agency staff go into the room of a female to deliver their personal care. We checked the person's care plan which stated they did not have a gender preference. However, the person had been distressed, calling out through the morning, before staff attended to them. Female staff were available, 1 was sitting in the lounge area, yet staff had not considered it would be more appropriate and preserve the person's dignity for a female member of staff to carry out their personal care.
- Staff told us people were cared for in bed for reasons other than preference or health needs. Staff said some people were kept in bed as they were at risk of falling, and some care plans also stated this. Other reasons given were lack of time to get people up every day. For some people, no reason was known. Some relatives told us they were concerned about their loved ones not getting up regularly and fears they may lose their mobility. One relative told us, "When I visited, she was in bed with her underwear and t-shirt. They said in the book they left her in bed as she had no skirts or trousers and I looked in the wardrobe and there were plenty."

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 offered opportunities to provide stimulation and reduce the risk of social isolation in all units. Some units supported people with less complex needs, and they had more opportunities to engage in some activity. The relatives of people living in these units told us they were happy with the level of activities on offer for their loved ones.
- However, there was a lack of engagement and stimulation for other people. Some people sat in the lounge, although there were less people sitting in the lounge on 2 units than others. There was little stimulation, and people who became confused or anxious would cause other people to become frustrated. When this occurred, staff were often not seen to offer reassurance to either person, to offer stimulation and de-escalate a potential altercation between people.
- An afternoon of entertainment was held on 1 unit during the inspection. Although staff told us anyone could attend from any unit, most people with more complex needs and who may become anxious from 2 units were less likely to be able to attend. One visiting relative told us they were worried their mother had been, "Left in their room without stimulation, not even the TV on, staring at the four walls. If I didn't come in this might not have changed. I asked staff if she has been in bed all day? Staff said we might not be able to

get her up every day. I said she must be up every day, she needs to be with other people."
● The provider told us they planned to have 5 activities co-ordinators, however, at the time of the inspection there were only 2. The activities co-ordinators were enthusiastic and had ideas and plans, but they were not able to fulfil the needs of all people living in the service.

The provider and registered manager failed to provide appropriate support in a person-centred way. This was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
● Not all complaints received to the service had been officially logged within the complaints file. For example, we saw complaints within 1 of the units had been recorded in the handover sheet, and relatives told us they had complained. There was no record of these complaints within the provider's complaints log, and therefore the provider could not be assured relevant action had been taken to address the concerns.
● The complaints that had been properly logged had not always recorded the outcome of the complaint, or if the person was satisfied with the response.
● There was no system to look for and act on any trends identified within the complaints logged at the service. Two complaints had similar themes, including a lack of personal care and items going missing from the same unit. There was no detail of what action had been taken to address this and share any improvements with staff.

The provider and registered manager failed to follow a process to investigate and monitor complaints. This was a breach of Regulation 16 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● The provider shared a new complaints logging system with us after the inspection.

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

● Basic information about people's communication needs was written in their care plans. Information could be provided in formats to suit individual if needed, although we did not see much evidence of this.
● Some relatives told us their loved ones were not always supported with their communication needs. One relative told us their loved one was not supported to wear, or charge their hearing aid, therefore they would be unable to communicate with staff.

We recommend the provider seeks guidance from an appropriate source to increase the use of accessible information to meet people's need

End of life care and support
● People had an end of life care plan. It was not clear in some care plans how much involvement loved ones had in the development of the plan. However, some care plans were good, setting out people's wishes, such as if they wanted to remain in the care home, or go to a hospice at the end of their life.

Inadequate

Is the service well-led?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The predominant culture of the service was not person centred, inclusive or based around people's needs. Some units were functioning better than others. Most of our concerns were based around 2 units. In these, there was a high level of agency use, people's needs were higher, and the environment was poorer. More people were living in these 2 units
- Prior to the inspection, the provider had swapped 2 units, people moved from 1 to the other. The provider explained they had sound reasons for doing this, to provide the people affected with a better quality lifestyle. However, there was no evidence people had been fully consulted. Mental capacity assessments had not been carried out on those people who may have lacked the capacity to consent. A best interest decision making process was not evidenced. Relatives told us they were very disappointed as they were promised the current staff who knew people would move too but this had not happened. Few staff had moved with people.
- We observed staff not speaking in English when communicating with each other, despite sitting with people. Some relatives also spoke of their concerns about this.
- Staff morale was low in some units. Unit managers and deputy managers told us they did not have the opportunity to keep care plans up to date or to observe and check staff practice, including agency staff, as they were too busy. Staff on 1 unit said, "Paperwork is piled high, it is chaotic, and nothing can be organised." Unit managers did not have any hours that were supernumerary, they were always on shift, and they told us this was why they could not keep up with their work. We fed this back to the provider who told us they had changed the working patterns of unit managers after the inspection.
- People's care plans and risk assessments did not include the detail and guidance needed to be sure people received care that was personal, reflected their individuality and met their needs. We have described how the individual guidance for staff to be able to provide good quality care in situations such as during experiences of agitation, diabetes care and their eating and drinking needs was not sufficient.

The provider and registered manager failed to keep accurate records and to operate a robust system to monitor the quality and safety of the service provided. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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; Continuous learning and improving care

● The management of the service was not robust and did not provide the leadership needed to make sure people received good quality care and protected them from the risk of harm.

● The provider had a process for monitoring the quality and safety of the service. However, these were not robust and did not provide clear oversight of people's care across the service. Completed audits did not pick up the many areas that we found needed serious improvement.

● Regular medicines audits were in place, however we were not assured these were always effective as some of the concerns we found had not been picked up. Actions plans were not competed to ensure issues were resolved.

● Audits were undertaken to check care plans. However, these did not focus on quality, accuracy of information or the individuality of people. Staff told us the focus was on checking the care plans were in place and had been reviewed rather than what was written in the care plan. We found issues with the accuracy of people's records, inconsistency, and lack of detail. This had not been picked up by the management team.

● People's care plans were ambiguous which could lead to poor care and safety concerns. Care records were not specific and used terms such as 'regular'. For example, one person's care plan said they were at risk of strangulation from their call bell, staff were guided to make regular checks. They were also at risk of falling out of bed and required position changes when in bed. The guidance for staff also said to make regular checks. This placed the person at risk of harm as different staff, including agency staff, may have differing views on what 'regular' meant. This had not been picked up by the management team.

● Handover records between shifts was not always accurate. We checked the records in relation to 2 people and the information was not consistent with the information in their care plan. For example, the record stated for 1 person, they were continent of urine when in fact they were incontinent. This meant people's safety and care may be compromised as there were high numbers of agency staff who may not know people's needs.

● Incidents were not always recorded when people had an episode of anxiety resulting in agitated behaviour. This meant this type of incident was not monitored from one month to the next by the management team to support prevention and improve outcomes for people.

● Complaints and safeguarding concerns were not monitored to enable improvements to be made across the service.

● Registered persons are required to notify the Care Quality Commission (CQC) about events and incidents such as abuse, serious injuries and deaths. The provider and registered manager understood their role and responsibilities and had notified CQC about all important events that had occurred. However, we found incidents that had not been reported by staff so we could not be assured all appropriate events and incidents had been notified

The provider and registered manager failed to keep accurate records and to operate a robust system to monitor the quality and safety of the service provided. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had taken over the service on 30 August 2022 and told us they had been working hard to make improvements but acknowledged they had a lot of work to do to improve further. They said they were passionate and had plans and wanted to provide a high quality service, but knew they had many basic areas to get right first. People's basic care needs were not met.

● The provider shared that recruiting good quality staff was a big issue that they were working hard to rectify. They told us maintaining and improving staff culture and skills had also been a focus since they took over the service. However, we found many concerns around staff culture as described through this report.

● Some staff were happy with the changes made so far and felt positive about the future. Some staff fed back how supported they felt, although this was not the case for many staff.
● Meetings had taken place with people, relatives and staff to share information and obtain their views since the provider had taken over the service.
● The provider had recently completed surveys with people, relatives and staff to anonymously seek their views of the service. Some areas for improvement were highlighted. The provider said they intended to action these and would carry out further surveys to check progress.

Working in partnership with others
● The management team were involved in local networks and were signed up to Skills for Care to receive updates and engage in forums and meetings to keep up to date.
● People were referred to health and social care professionals, and the management team knew how to go about seeking community support.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider and registered manager failed to provide appropriate support in a person-centred way.

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 The provider and registered manager failed to ensure care was provided in a caring and dignified way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider and registered manager failed to ensure people's rights were maintained and upheld.

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

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider and registered manager failed to follow a process to investigate and monitor complaints.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider and registered manager failed to have safe and robust recruitment processes in place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider and registered manager failed to deploy staff appropriately and safely. The provider and registered manager failed to ensure staff were appropriately skilled.

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 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider and registered manager failed to assess and monitor the risks to the health and safety of people or do all that was reasonably practicable to mitigate risks. The provider and registered manager failed to manage medicines safely.

The enforcement action we took:

We imposed conditions 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
Treatment of disease, disorder or injury	The provider and registered manager failed to keep accurate records and to operate a robust system to monitor the quality and safety of the service provided.

The enforcement action we took:

We imposed conditions on the provider's registration.