Methodist Homes

Rushden Park

Inspection report

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07 February 2023
09 February 2023
14 February 2023

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31 March 2023

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Rushden Park is a nursing home providing personal and nursing care to up to 68 people. At the time of our inspection there were 58 people using the service.

People's experience of using this service and what we found
There was a lack of effective oversight and monitoring. This had resulted in poor outcomes for people using the service. Complaints made by people and relatives were not always responded to and investigated without delay.

People were not protected from risks. This included risks associated with urinary catheters, pressure care, constipation, specialist feeding regimes/interventions and environmental risks. Safeguarding systems and processes did not always protect people. We were not assured safeguarding concerns reported by staff were recorded and investigated appropriately by the registered manager or provider.

People were not always supported by enough staff to meet their needs. Staff told us there was not always enough staff on shift which had an impact on people's care. Staffing levels had an impact on the support people received with their food and drinks.

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.

Not all staff had received training to ensure they had the necessary skills and knowledge to meet the needs of the people they supported. Staff received regular supervision meetings. However, we were not satisfied these were effective in supporting staff. There was no system in place to monitor and observe staff practice to identify areas of development.

People experienced task led care which resulted in their dignity not being promoted or protected. People were not always supported to maintain their independence and have the opportunity to take part in activities and access the local community.

Staff had access to people's care plans and risk assessments however, we were not confident these were read, understood and followed by staff.

The home was clean and tidy, and measures had been taken to reduce the risk of the spread of Covid-19 and other infections.

People were able to choose their meals from a daily menu and staff ensured people had access to drinks by placing them within reach. Staff worked in partnership with health and social care professionals to maintain

people's health. For example, the local GP and the district nurse regularly visited to provide clinical care to people.

The provider was open and transparent during and following the inspection and developed an action plan to address the concerns found during the inspection.

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

Rating at last inspection
The last rating for this service was Requires improvement (published 26 January 2022).

Why we inspected
The inspection was prompted in part by notification of an incident following which a person using the service died. This incident is subject to further investigation by CQC as to whether any regulatory action should be taken. As a result, this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk, staffing levels and management oversight. This inspection examined 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.

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

Enforcement
We have identified breaches in relation to safe care and treatment, staffing levels and training, safeguarding, consent to care, personalised care, management of complaints and managerial oversight at this inspection.

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

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

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions 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 effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not always caring. Details are in our effective findings below.	**Requires Improvement**
Is the service responsive? The service was not responsive. Details are in our effective findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our safe findings below.	**Inadequate**

Rushden Park

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.

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.

Inspection team
The inspection was carried out by 2 Inspectors and 1 Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Rushden Park 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. Rushden Park 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. The registered manager was present during our inspection on 7 February 2023, however, they were absent from the service on 9 and 14 February 2023. Interim management arrangements were put in place by the provider during the inspection. This included a registered manager from another service to support the day to day running of the service and

support staff to address the concerns found 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 the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 8 people and 14 relatives of people who used the service about their experience of the care provided. We spoke with 13 members of staff including the registered manager, care assistants, nurses, area manager, and the regional manager. We also spoke with the interim management team. We reviewed care plans and records for 9 people. This included people's medicine records and daily care records. We also reviewed various records relating to the day to day management of the service, quality assurance and key policies and procedures.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question Requires Improvement. At this inspection the rating has deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management;

- People were not protected from the risks associated with urinary catheters. For example, we saw one person's urinary drainage leg bag full of urine, not draining, as the tap had not been opened by staff. This resulted in the urine flowing back up the tube. This posed a significant risk to the person's health and placed them at risk of infection.
- People were at risk of pressure damage. People's air mattress settings were not always set according to their individual weights to reduce the risk of pressure damage. One person with significant pressure damage had no record of their weight within their care file. Staff were prompted during the inspection to calculate the person's weight to ensure the correct setting, inspectors found their air mattress set at 20kg above their actual weight . This demonstrated a failure to adequately assess and manage the risks of pressure damage, placing people at risk of harm.
- People's continence care plans did not contain information on what action staff should take when supporting someone at risk of constipation. For example, 3 people's care plans did not detail how many days of no bowel movements should be a concern, what medical and therapeutic intervention could be used and who it should be reported to. One person had no bowel movements for 8 days and records did not evidence staff contacted the person's GP for advice. This placed people at risk of health deterioration and harm.
- Monitoring of people's daily nutrition and hydration intake was inconsistent. Percutaneous endoscopic gastrostomy (PEG) administration records reviewed for 3 people showed nutrition and fluid intakes were not being totalled to ensure people's individual daily nutrition and hydration targets were met. This placed people at increased risk of malnutrition and dehydration.
- People were not always protected from the risks associated with their health conditions. One person required support from staff to manage their diabetes. There was no care plan or risk assessment in relation to diabetes care and management. This meant staff did not have adequate guidance to identify or to know what action to take should the person experience too high or too low blood sugar levels.
- Environmental risks to people's safety were not always assessed and mitigated. For example, risk assessments had not been completed for the potential risk of harm to people accessing boiling water in the kitchenette/dining areas. People with delirium and dementia who were unable to ensure their own safety could access the boiling water as it was not secure. This placed people at risk of burns, scolds and injury.

The provider had failed to assess, monitor and mitigate risks to people's health and safety. This was a breach of regulation 12(1) Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● People did not always receive their medicines safely. Instructions in place for the administration of medicine via PEG were not always followed by staff. Records completed by staff showed limited evidence of water flushes between each medication for 3 people. This is important to prevent any incompatibilities between medicines. This placed people at risk of harm.

The provider had failed to assess, monitor and mitigate risks to people's health and safety. This was a breach of regulation 12(1) Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Nursing staff administered people's medicines and had been assessed as competent to administer medicines safely.
● PRN (as required medicines) protocols were in place, explaining the medicine, what it was prescribed for, when to offer the medicine or how to identify when the person may need the medicine.

Systems and processes to safeguard people from the risk of abuse
● Safeguarding systems and processes did not always protect people. We found a number of notifiable incidents that had not been reported to the local safeguarding authority in line with the providers policies, including 4 incidents of harm to 2 people. This meant incidents had not been appropriately investigated by the relevant external agency.
● Staff had received training and understood the signs of abuse and how to report any concerns. However, we were not sure safeguarding concerns reported by staff were recorded and investigated appropriately by the registered manager or provider. One staff member told us how they had formerly reported to the registered and regional manager an incident of abuse by a fellow staff member against a person. They told us their concerns were not taken seriously and dismissed with no further action taken.
● Safeguarding concerns reported by people's relatives were not always recorded and investigated appropriately by the registered manager. One relative told us they had reported that their father had raised concerns of being rough handled by night carers. This was raised in an email to the registered manager in September 2022. The provider was unable to show evidence of this allegation being recorded and investigated appropriately to protect the person from the risk of abuse. This placed people at risk of harm.

The provider failed to ensure systems and processes to safeguard people from the risk of abuse were used effectively. This was a breach of regulation 13(1) Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● During the inspection, the provider's safeguarding lead began the process of reviewing records to ensure incidents were appropriately reported and investigated.

Staffing and recruitment
● People who required support from staff on a 1 to 1 basis for their own safety, did not always receive this support. This led to 2 people sustaining injuries from unwitnessed falls and placed people at risk of harm.
● On the first day of inspection, 2 people required support from staff on a 1 to 1 basis to ensure their safety. Inspectors observed 2 people not to be receiving their 1 to 1 care. The nurse told inspectors this was due to not having enough staff and staff were observing from a distance. One person, who was assessed as requiring 1 to 1 support, entered the dining area without staff supervision and proceeded to grab the hands and kick the shins of another person living at the service. This showed people were at risk of harm due to inadequate staffing levels.
● Staff told us there was not always enough staff on shift which had an impact on people's care. One staff member said, "Sometimes we have to tell people that the hoist has broken so we can't get them [people] up

today. It's a lie, it's because we don't have enough staff." Another staff member said, "I often come away thinking this does not feel safe, staff are running around trying to keep up."
● One relative told us, "I dread going at the weekend as it's even worse, there's fewer staff. I turn up at 11am and [person] is soiled and a mess and there's smells." Another relative said, "There's been a few times when [person] has asked to go to the toilet at mealtimes and there's not enough staff, so they wet themself. They wear pads."
● The registered manager used a dependency tool to calculate the staffing numbers required to meet people's needs. During the inspection, the dependency tool was reviewed by the provider and staffing levels were identified to be lower than required. This was rectified by the provider immediately by using agency staff to increase staffing numbers.
● Following an incident within the service, the registered manager conducted a check of the information held within the service for agency members of staff, provided by the recruitment agencies. The registered manager identified several members of agency staff who only had a standard Disclosure and Barring Service (DBS) check. A standard check does not show whether a person is barred from working with children or adults. Following this, the registered manager and admin manager implemented additional checks to ensure agency staff had enhanced DBS clearances before working with the vulnerable people in the home.

The provider had failed to ensure they had enough suitably trained 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.

Learning lessons when things go wrong
● Accidents and incidents were not reviewed on a regular basis to identify themes and trends and to learn lessons. We have reported on this further in the well led section of this report.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● The provider supported people to have visitors at the service. Relatives told us they were able to visit their family members.

Inadequate

Is the service effective?

Our findings

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

At our inspection on 19 November 2019 we rated this key question Good. At this inspection the rating has deteriorated to Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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

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

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

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● Where the provider felt people were not able to make decisions for themselves about their care and treatment, mental capacity assessments had not always been completed and best interest decisions recorded. This meant the provider was not always following the principles of MCA and could not be sure what decisions people could make for themselves and ensure they were supported in the least restrictive way possible and in their best interests.
● There was no system in place to monitor applications, authorisations and conditions of DoLS. At the time of the inspection, 2 people were deprived of their liberty as they were under constant supervision for 24 hours a day. The appropriate assessment and legal authority for this could not be evidenced.

The provider had failed to ensure they acted in accordance with the Mental Capacity Act 2005. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Care records showed where people had appointed a lasting power of attorney (LPA) for health and welfare or finance this was recorded. An LPA is a person that acts in the persons best interests when making decisions on their behalf.

Staff support: induction, training, skills and experience

● Not all staff had received training to ensure they had the necessary skills and knowledge to meet people's needs. This included training in catheter care and behaviours that present a risk to self, others or staff. Issues identified during the inspection demonstrated staff lacked knowledge in these areas.

● Staff were offered an induction when joining the service. This included reflections, questions to assess knowledge and a practical skills check. However, we were not sure all staff had completed their induction, as evidence was not made available as requested for all staff reviewed by the inspection team.

● Staff received regular supervision meetings. We were not satisfied these were effective in supporting staff. One staff member told us, 'I don't know how things I raise are escalated, I've never had any feedback, I think things are just filed.' Another staff member said, 'I am meant to have a supervision with a nurse. However, the last two I was given the paperwork, told to do it at home, and hand it back. I had no discussion or time with the nurse they just logged it as a supervision.'

● There was no system in place to monitor and observe staff practice to identify areas of development. The registered manager advised they observed staff and would address any concerns, however, as this was not recorded, we could not be assured this happened.

The provider had failed to ensure they had enough suitably trained 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.

● Once raised by inspectors, the provider took action to address the concerns with staff competency and skills and sourced and provided additional training.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● Staff had access to people's care plans and risk assessments however, we were not assured these were read, understood and followed by staff. One staff member said, "We don't have time to read them, but they don't always hold up to date information in them anyway." Another staff member told us, "There are care plans and risk assessments and if I had time to read them, they would probably be helpful. I've never read a whole care plan."

● People's needs were assessed before they moved into the service. Pre-assessment paperwork was completed to identify the person's needs.

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

● Staffing levels had an impact on the support people received with their food and drinks. One relative told us, "It can be up to half hour late with meals." Another relative said, "The staff are run off their feet and definitely understaffed. I have helped people in the lounge to get a drink." One member of staff told us, "We give them [people] finger foods at teatime so they eat themselves because we don't have the time assisting with something like beans on toast."

● There was information in people's care records about their dietary needs. We saw staff followed the guidance in these plans. The cook was aware of people's dietary needs including people who required their fluids thickened or foods fortified.

● Where people's weight was monitored by staff and the registered manager, weight loss was noted and professional advice was sought from a dietician.

● People were able to choose their meals from a daily menu. People had access to drinks in their rooms and these were placed within reach.

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

● The provider had not considered adapting the design and decoration of the service in line with best

practice to support people living with dementia, such as bold face and contrasting signs to help people orientate and navigate themselves around the home.

● People's bedrooms were individually decorated with personal items. Each bedroom had access to an en-suite toilet and wash basin.

● During the inspection, refurbishment was taking place in the lounge and dining areas of the home. The registered manager advised refurbishment work was ongoing.

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

● Staff worked in partnership with health and social care professionals to maintain people's health. For example, the local GP, dieticians and specialist diabetic nurses.

● Information was made available to other healthcare professional when required, such as ambulance service, to ensure people's healthcare and other needs were known. This included information on people's medical history, GP, tissue viability, diet and fluid support and mobility support.

● Records demonstrated people's relatives had been contacted to update them on people's health and wellbeing.

Requires Improvement

Is the service caring?

Our findings

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

At our inspection on 19 November 2019 we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- People were not always treated with dignity and respect and their independence was not always promoted.
- People's experience of care was affected by the insufficient staffing levels in the home. One staff member told us, "I've sometimes given someone the bed pan rather than taken them to the toilet as I don't have time." Another staff member said, "Sometimes people get left in bed. People don't get up at their preferred time, but we try to explain and tell them we are doing our best."
- Observations showed people received care that was rushed and task based. A staff member said, "They [management] want you to rush them [people] like a conveyer belt."
- Staff ensured people's privacy and dignity during personal care by ensuring bedroom doors were shut and curtains were closed. We saw staff knocking on doors before they entered a room. We saw people's bedroom doors were shut when a visitor was present.
- People and their relatives told us care staff were kind and friendly. One relative told us, "Staff are undervalued. I'm so grateful with how they [care staff] look after mum." One person told us, "Some of them [care staff] are cheeky, we have a laugh, they are nice."

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

- There was no evidence people or their representatives had been involved in reviewing their care plans. This meant people's wishes about how they wanted their care delivered may not have always been known.
- Care plans detailed where people were able to make a choice about their care and support. This included choices of meals and drinks.
- There was information about local advocacy services available to people. An advocate is an independent person who can help someone express their views and wishes and help ensure their voice is heard.

Inadequate

Is the service responsive?

Our findings

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

At our inspection on 19 November 2019 we rated this key question Good. At this inspection the rating has deteriorated to Inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; 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; End of life care and support

- Important information about people's life history, interests and preferences were not always recorded in people's care files. This included information around favourite foods, personal care preferences, religious needs, favourite television programmes, family history and activity preferences. This meant we could not be assured staff knew people well to provide personalised care. One staff member said, "When staff are short on the ground, we have no time to chat to people, no time to get to know people."
- People were not supported to take part in activities they enjoyed doing. Most people spent the majority of their time in their bedrooms alone. We observed this during the inspection and records confirmed this. People were at risk of deterioration of their emotional wellbeing due to a lack of a stimulating environment.
- The provider had not taken account of people's views, needs and preferences when allocating staffing levels. One person told us they sit in bed in their room all day watching TV as they are immobile and unable to attend any activities. One person told us, "I do nothing apart from hang man on a Monday. I would like to go to the pub." One person was denied access to the community during the inspection to make a personal purchase as no staff member was available to support.
- One relative told us, "They [staff] don't do any activities that [person] can join in with. [Relative] doesn't get any 1 to 1 time, the girl [staff] who was on activities has now left. She used to have a chat with him, now he just sits and stares out of the window or watches TV."
- People's end of life care plans were not always person centred. Information around people's wishes and choices in relation to their end of life care was limited. For example, if they wanted music playing, physical contact or hymns/prayers. This meant people's end of life care wishes may not always be supported in the way they wanted. One staff member told us, "We used to be praised for our end of life care, not anymore, we don't have time to sit with people who are dying."

The provider had failed to ensure care was planned and delivered in a personalised way. This was a breach of Regulation 9(1) Person-centred care Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- People had support from a Chaplain and church services were made available to people to attend each week. During the inspection, the chaplain had arranged for a funeral service to take place for people to attend and pay their respects.
- The appropriate documentation was in place for people where they had expressed a wish to not be

resuscitated, known as DNACPR (Do not attempt cardiopulmonary resuscitation).
● Staff had received training in end of life care. Following the inspection, the provider advised CQC they are in discussions with the local Palliative Care Team to seek further training for staff.

Improving care quality in response to complaints or concerns
● Complaints made by people and relatives were not always responded to and investigated without delay.
● We were not confident staff understood how to respond when they received a complaint from a person or relative. One relative told us, "I reported an incident in September 2022 or October 2022 when [person] was ringing me and I heard a carer say, 'stop calling people, no one wants to talk to you'. I reported it to the lead carer on shift. I've had no response to my complaint."
● The registered manager and provider did not always respond to complaints made by people or relatives. During the inspection, a relative told us an email with concerns had been sent to the registered manager on 26 September 2022 with no response. This was followed up by the relative via a 'contact us' form on the provider's website and they had not received a written or verbal response from the provider or registered manager. Following the inspection, the provider confirmed the complaint had not been dealt with as per the provider's policy.
● We received mixed feedback from people's relatives in relation to raising complaints with nursing staff and the registered manager. One relative said, "You can soon make some enemies. Someone's relative told us not to say anything as 'you'll be an enemy'."

The provider had failed to operate an effective system to identify, receive, record and handle complaints. This was a breach of Regulation 16(1) Receiving and acting on complaints Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.
● People's communication needs were considered as part of the admission assessment and people's care plans described the level of support required. For example, uses a hearing aid or wears glasses.
● Although improvements were required in the environment to support people with communication and understanding difficulties, written information could be made available in other formats where required such as different languages or large print.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question Requires Improvement. At this inspection the rating has 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Systems and processes were ineffective in assessing, monitoring and improving the quality and safety of people's care. Systems and processes failed in ensuring care was delivered in line with people's assessed needs as documented within people's care plans.
- Audits of care plans, daily notes and tasks had failed to identify the shortfalls found during the inspection. This placed people at an increased risk of harm.
- The lack of provider oversight contributed to the failings we found during this inspection. They had failed to ensure systems and processes were implemented to regularly monitor the safety and quality of the service and drive positive change to enhance people's experience of care.
- Accidents and incidents were not monitored on a regular basis to identify themes and trends and to learn lessons. The provider had failed to review people's care plans and risk assessments after each incident to reduce the likelihood of reoccurrence. This placed people at an increased risk of harm.
- Systems had failed to identify missing documents within staff employment files. This included identification documents and confirmation of right to work documents.
- Call bell audits completed by the registered manager reviewing staff response times to call bells was not always effective in identifying prolonged waiting times. This meant people were at risk of not having their needs met, in a timely way.

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

- We identified concerns in relation to the culture of staff at the service and received concerns about the registered manager and their approach with promoting an open culture. One staff member told us, "We have staff meetings, but they are negative, we get no praise, just get told we're not doing enough. You get shouted down and told you're wrong." Another staff member said, "Sometimes it's hard to raise concerns. Sometimes the manager only listens to certain carers."
- We received mixed feedback from people and relatives about some of the nursing staff. One relative told us, "[Staff member] is abrupt and we have had to ask for medication twice, even morphine. [Staff member's] attitude stinks, they seem fed up. The others are fine." One person told us, "You keep telling them [staff] there's things wrong and they just laugh at you. [Staff member] wasn't very happy when I told the manager, so I'm keeping quiet." Another relative told us, "Whenever I ask anything, I'm met with this look like I'm a pain or shouldn't be asking."

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

● We saw limited evidence of attempts to seek feedback from people and their relatives. Meetings had taken place for people and relatives' however, these were infrequent. The meeting minutes for a residents meeting held in September 2022 showed residents gave feedback in relation to staff not understanding people's needs and the timings of meals. Action plans had not been put in place as a result to ensure any areas of improvement were addressed. The provider had failed to ensure effective systems were in place to seek the views of the people using the service and improve the quality of the care.

The provider had failed to operate effective systems and processes and provide consistent and effective leadership to assess, monitor and improve the quality and safety of the services provided. This is a breach of Regulation 17(1) Good governance Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● A review of records indicated statutory notifications had not always been submitted to CQC. We are reviewing this and will report on this at the next inspection.

● During the inspection it was identified the provider's Statement of Purpose did not contain up to date information of the services provided at the nursing home including the service types and the service user bands for example, adults aged under 65. A statement of purpose is a legally required document that includes a standard set of information about a provider's service. We are reviewing this and will report on this at the next inspection.

● During and following the inspection, the provider implemented an action plan to address the shortfalls identified during the inspection and to continue to assess and monitor the safety of people's care. The provider was working with staff, people and relatives to build trust and respond openly to concerns raised. This will need to be continued and embedded in practice. The provider has informed CQC of their progress with regular updates.

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 registered manager and provider had not understood and acted on the requirements of the duty of candour. Duty of candour is a requirement for providers to be open and honest with people when things have gone wrong with the care they received.

● The provider accepted that there had been service failings and worked with CQC during the inspection to immediately take action to improve the safety and quality of care. This will need to be continued and regularly reviewed by the provider to ensure people's safety.

Working in partnership with others

● During the inspection, the provider worked closely with the commissioning funding authority to seek alternative care provisions for the 2 people requiring 1 to 1 support from staff. On the last day of inspection, both people had been moved to new services to maintain theirs and others safety.