Sanctuary Care Limited

Briggs Lodge Residential and Nursing Home

Inspection report

London Road
Devizes
SN10 2DY

Tel: 01380711622
Website: www.sanctuary-care.co.uk

Date of inspection visit:
19 February 2020
20 February 2020

Date of publication:
07 April 2020

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Briggs Lodge Residential and Nursing Home is a purpose-built nursing home in Devizes providing personal care for up to 66 older people. At the time of our inspection the service was only providing residential care. At the time of our inspection there were 24 older people living at the service on the ground and first floors. The second floor of the home had been registered to be used by another of the provider's services as a separate location. This arrangement was in place until June 2020 whilst refurbishment works were being carried out. After this time the people living on the second floor planned to move back to their home. The second floor was not inspected as part of this inspection.

People had their own rooms with en suite shower rooms. Each floor had its own lounge and dining area. There were also communal rooms such as a cinema, garden room, café and hairdressing salon. There was a garden accessible from the ground floor.

People's experience of using this service and what we found
People were not always supported by sufficient numbers of trained staff. The manager had not made attempts to obtain agency staff to cover the shortfall. People and staff told us the service was regularly short of staff which meant people had to at times wait for their care.

Whilst the provider's quality monitoring of the service was identifying some improvements needed to improve safety, the concerns about staffing were not being addressed.

People and staff were not confident with the management approach at the service. Staff did not always feel able to approach the manager or feel they were valued. People were worried the service was not being well-led.

Staff had not been trained or supported effectively. There was a delay in providing moving and handling training for new staff. The provider told us they were organising a moving and handling trainer to be based at the home.

Risks to people were not always managed safely, and guidance had not been updated when needed. This meant staff were not sure about consistent approaches to use when supporting people. Care plans contained conflicting information and lacked details in some areas. Where additional monitoring was needed there were gaps in the recording, or no records of the care provided. People's records were not always stored securely.

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 medicines were not always managed safely. People did not always have their medicines in stock which meant there were times they could not have their medicines. People's records for their prescribed topical creams were not always completed in full. This meant the provider could not be sure people had their creams applied as prescribed.

People's views about the food were mixed, some people did not like the food, however, some people did enjoy their meals. People had not been involved in planning the menus. There was a choice of two options daily and people could order alternatives if they wanted. People could eat where they wished.

People told us they had not seen a care plan and not been involved in planning their care. Pre-admission assessments had been carried out, but the forms used were tick box based. This meant the information gathered was limited. People's life histories had not always been sought which helps staff to work with people with dementia effectively.

We found activities for people with dementia were limited and the environment was not engaging. Staff had not always had dementia training and struggled to support people effectively.

People could have visitors when they wanted without any restrictions. People and relatives told us staff were kind and caring though rushed and had too much to do. Two relatives told us the care their family member received was good and they thought their relative was safe living at the home.

The home was clean throughout and staff followed good infection prevention and control practice. The kitchen had been inspected by the local authority and achieved a rating of '5' which meant it had very good hygiene standards.

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 on 12/04/2019 and this is the first inspection.

Enforcement
We have identified breaches in relation to the regulations for safe care, good governance, need for consent and staffing at this inspection. Please see the action we have told the provider to take at the end of this report.

Follow up
We will meet with the provider to discuss how they will make changes to ensure they improve their rating to at least good. We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Briggs Lodge Residential and Nursing Home

Detailed findings

Background to this inspection

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

Inspection team
This inspection was carried out by two inspectors and a medicines inspector.

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

The service had a manager who was in the process of registering with the Care Quality Commission. This means that once they are registered they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service. This included information of concern received from staff and family members. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account

when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with nine people who used the service and two relatives about their experience of the care provided. We spoke with eight members of staff, the manager and regional manager. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included seven people's care records and multiple medicines records. We looked at five staff files in relation to recruitment, training and supervision. A variety of records relating to the management of the service were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance data. We contacted the Wiltshire Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We also contacted three healthcare professionals for their views on the care and supported provided.

Requires Improvement

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 for this newly registered service. This key question has been rated Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment; Systems and processes to safeguard people from the risk of abuse

- Prior to our inspection we received a series of concerns about the service being short of staff. We asked the provider to send us a response to these concerns which they did. They told us the service had sufficient staff numbers based on the provider's dependency tool calculations. However, staffing numbers continued to be an issue at this inspection for people and staff.
- People we spoke with told us there were at times not enough staff. Comments from people included, "There should be more staff, I have to wait sometimes for them to answer my bell" and "It seems to be short of staff here, you have to wait at mealtimes sometimes."
- Staff we spoke with told us there were not enough staff. Comments from staff included, "There is not enough staff, but they are recruiting. If staff go sick they try and cover with their own staff" and "We get put on as there is not enough of us."
- People's comments about feeling safe were mixed. Some people did not feel safe due to the concerns about staffing. People said, "I don't feel 100% safe" and "It is chaotic here at 8am, either half a dozen staff show up or no-one, so they have to phone around. That nervousness transfers to us. Don't feel like it is a rest home as I don't feel relaxed here." Some people told us they did feel safe at the home. People said, "I feel safe, it is very nice here" and "No complaints here, I feel safe."
- Staff rotas demonstrated that there were times when staffing numbers fell below the provider's expected safe staff ratio of 1:10 at night. For example, there were three nights in January 2020 where there had been two night care workers on duty instead of three. This was a concern as the staff were caring for people living on two floors, some of whom lived with dementia and four people needed two staff to support them. This meant whilst two members of staff were supporting one person there were no staff on the other floor or available to monitor people's safety.
- There was also concern about staff being included in the safe staffing numbers on the rota when they had not received their training in moving and handling. There were some nights where three members of staff were working, however, there were times when only one of those staff had received moving and handling training. This meant only one of the members of staff were safely able to support people to move and re-position. There were four people who needed two staff to help them move or re-position. Comments included, "There are young girls on night duty who have had no training" and "Staff are counted in the numbers on the rota even though they are not trained."
- The manager told us during our inspection that the home did not use agency staff. We checked staff rotas and observed there was no agency staff recorded as being used. One relative told us, "Staff do ring in sick and there is no agency used." One member of staff told us, "We don't use agency staff which staff find frustrating."
- Care staff were observed to have additional duties to carry out which took them away from care activity.

The dining rooms on both floors had a kitchenette area where crockery was washed up following meals and drinks. We observed care staff were regularly emptying the dishwashers, loading the dishwashers and keeping the kitchen areas clean and tidy. This type of domestic activity was carried out in addition to their caring roles.

● We observed two occasions where a person was at risk of falling and we had to wait with them till there were staff available to help. The person had slippers which did not fit well and were slipping off when they were walking. We intervened until staff were available to help them.

We found no evidence that people had experienced harm, however, failing to deploy sufficient staff to safely meet people's needs put them at risk of harm and was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were being supported by staff who had been recruited following the required pre-employment checks. This included checks on applicant's previous employment history and a disclosure and barring service (DBS) check. DBS checks helps providers make safer employment decisions.

● Staff had received training on safeguarding and were able to tell us what they would do if they were concerned. Staff were also familiar with the whistleblowing process and how to use it. Whistleblowing is when staff report any wrongdoing at work.

Assessing risk, safety monitoring and management; Using medicines safely

● Staff's assessments of risks to people were inconsistent and records did not always have detailed information about the risks to people's safety and how they were to be managed. For example, one person had a smoking risk assessment in place. The assessment stated they had on two occasions lit cigarettes in their bedroom. The assessment did not give detailed guidance on how the risk was to be managed.

● One person had a risk assessment in place regarding their behaviours and the potential risk of harm to others in communal areas. The risk assessment stated, 'Ensure safe staffing levels to provide continuous monitoring when in communal areas.' There was no guidance about what might cause the person to experience distress, or what staff needed to do to support the person and others. We saw the person was at times unaccompanied by staff in the communal areas, with other people present. Risks had been identified but were not being managed.

● Guidance for staff to manage some risks had not been updated when people's needs had changed. One person had been assessed as at high risk of developing a pressure ulcer however their care plan had not been updated. There was a body map in place showing the person had already developed a reddening of a pressure point on their body. The guidance in place for staff about how often the person should reposition did not reflect that the person had become unwell. We informed the manager and regional manager of this who told us they would review this care plan without delay.

● People had been prescribed topical creams and/or lotions. We found gaps in the recording, so it was unclear if they were being applied. For example, we saw one person who had been prescribed medicated creams to be applied two or three times per day. The records demonstrated staff had applied this cream once a day on three days.

● People were not always able to take their medicines as prescribed as there were times when their medicines were not in stock. Whilst there was a system in place for ordering medicines, three people had missed doses of their medicines as there were none available. The manager told us the service was preparing to move to an electronic medicines management system which would help reduce this type of incident.

Whilst we saw no evidence of harm, failing to assess and manage risks to protect people from harm and failing to manage medicines safely, was a breach of Regulation 12 (Safe care and treatment) of the Health

and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider made sure safety checks to the building and equipment had been carried out. External contractors were employed to service equipment such as hoists, the passenger lift and fire extinguishers.
● The provider had produced a detailed business continuity plan which outlined the course of action needed for emergencies.
● People who were prescribed 'as required' medicines had a protocol in place to guide staff on how to administer this type of medicine.
● We observed staff administering medicines and saw their practice was safe.
● Risk assessments had been completed for people who wanted to look after their own medicines to ensure it was done safely.

Preventing and controlling infection
● The home was clean throughout and there were no malodours present in any area. Domestic staff were employed who carried out regular cleaning tasks according to set schedules. One person told us, "Cleaning is excellent the domestic staff here are excellent."
● Systems were in place to support staff to protect people from the risks of infections. This included different coloured laundry bags to separate soiled laundry and personal protective equipment (PPE) available for the staff.
● We observed staff used PPE when appropriate and washed their hands when needed.
● The local environmental health officer had visited the service to inspect the kitchen in July 2019. They had awarded a '5' rating which meant there were very good hygiene standards.

Learning lessons when things go wrong
● Accidents and incidents were reported and recorded appropriately.
● The manager reviewed the accident reports to identify if there were any measures needed to stop the event happening again. The regional manager told us there would be a de-brief, to identify any lessons learned or learning which needed to be shared with the team.

Requires Improvement

Is the service effective?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

● New staff had not always received sufficient training on how to carry out their roles effectively. There had been a delay in some staff being trained on moving and handling. Records demonstrated that 63% of staff had completed this training. We were told a training session had been booked for the staff who needed it.

● Staff who had worked at the service since it opened told us they had all received training prior to people moving in. However, due to the turnover of staff there were many new members of staff who had not received this level of induction. One member of staff told us, "Staff feel they have been thrown in the deep end, no training and no supervision."

● Throughout our observations we saw staff miss opportunities to promote conversations or interactions between people. We saw staff singing or whistling frequently, which broke the very quiet atmosphere. Staff also engaged regularly with one another in conversations about the songs they had been singing. Staff did not encourage people to join them in singing together. Staff told us they had not been given enough training on how to support people with dementia. One member of staff told us they struggled to work with people with dementia and had told the provider this. One healthcare professional told us, "Staff knowledge of dementia care is poor."

● We saw one daily record for a person who needed dietary support that demonstrated staff did not have the required skills to meet people's needs. The record stated, '[Person] is very agitated, shouting and hitting staff members. Food wasn't offered as [person] has thrown most meals today'. This record indicated the person was denied being offered food on that evening. This was despite there being no guidance in the person's care plan to restrict their choice in such a way. We raised this with the manager and operations manager who told us they would look into this practice.

● Staff had not always had the support needed to make sure they were carrying out their roles effectively. The manager told us they had a new system in place for staff supervision which started in January 2020. Prior to this date staff supervision had not been carried out consistently.

We found no evidence that people had experienced harm, however, failing to provide staff with appropriate support, training and supervision to enable them to carry out their duties was a breach of Regulation 18 (Staffing) 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 had a pre-admission assessment carried out by the management before they moved into Briggs Lodge. People told us they had met the management team and been asked questions.

● On the second day of our inspection one person was moving into the home for a short period of respite

care. We reviewed their pre-admission assessment and saw it did not contain enough information to give staff guidance on meeting the person's needs. The form was mostly tick boxes which did not provide personalised details. The manager told us this was an old assessment form and going forward they would be using a new form which had more room for them to write their notes.
● Records did not evidence staff supported people with their mouth care. We saw some detailed and specific care plans were in place for this, but records to confirm the person received this support were inconsistent. One person who needed support with their mouth care was only recorded twice as receiving this in the eight weeks prior to our inspection.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to 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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. We found improvement was needed.
● Assessments of people's mental capacity lacked detail about how the person had been supported to be involved in the discussions. No records seen showed what the person had been asked, or how the person had responded.
● Judgements made by the staff member assessing the person's capacity were at times inconsistently recorded in care plans relating to people's capacity and consent. In the mental capacity care plan for one person the information stated they did not have capacity to consent to the decision. Later in the same plan, the information stated the person was able to consent to the decision. This could be confusing for staff who do not know the person well.
● There were gaps in the records around the best interest process. This meant the service could not always demonstrate the least restrictive option had been considered.

Care and treatment had not been provided with the consent of the person or relevant person. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● One person had a DoLS authorised which had conditions attached. The service was meeting those conditions.

Supporting people to eat and drink enough to maintain a balanced diet
● People's views on the food were mixed. Comments included, "Food is ok", "We can ask for food and drink at any time", "Food is good overall but not always that hot" and "Food is rubbish, they use second class ingredients."
● There were no snacks available throughout the day for people to independently access. People who prefer to eat snacks or convenience foods rather than engage in a full meal did not have these options readily available to them.

● The manager had held one meeting for people since they had been in post. We could see that food was an agenda item. People present had been able to share their views. However, people told us they were not confident action would be taken. One person told us, "We used to have a monthly meeting with the chef, we don't anymore."
● People had not been involved in planning the menus. Whilst people could pre-order food if they did not like the menu choices, people wanted to be involved in this area of the service.

We recommend the service seeks advice and guidance on how to involve people in the planning and evaluation of menus.

● People were offered a choice at the table, staff showed people on plates the two options. This enabled people to visually see the option and smell the food to help them choose.
● People were able to sit where they wanted to eat their meals. People told us they liked some meals in their rooms and others in the dining rooms. They chose depending on how they were feeling.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● There was a handover system for staff to know about people's needs and any changes. Handovers were held at the start of the shift and there was a daily heads of department meeting.
● The provider used a handover book for staff to communicate with each other about people's needs. We saw on some days the record had not been completed at all and on other days there was information on people's needs. This system was inconsistent.
● Referrals were made to health and social care professionals when needed. Records showed people at risk of choking had been assessed and the guidance was included in people's care plans for staff to follow.
● We saw people being visited by community health care professionals, to receive support with having their wounds monitored. Relatives told us staff updated them with any information resulting from visits. One relative said, "Staff will ring me with any news."

Adapting service, design, decoration to meet people's needs
● Briggs Lodge was a new home which had opened in 2019. The home had three floors though at the time of our inspection the top floor was being used temporarily by another service.
● People told us they were happy with the environment and their rooms. One person told us, "I am happy with my room, I don't mind the view." Another person said, "I am happy with my room, I have got my own toilet."
● The corridors were wide and spacious, doorways were wide enough for a wheelchair to easily pass through. There was ample natural light and the home was tastefully decorated.
● People living with advanced dementia lived on the first floor, however, there were also people with dementia residing on the ground floor. There was a lack of signage available for people to navigate around the building independently. One person told us, "I get confused trying to find the dining room, there are no signs."
● We observed people with dementia walking in the corridors. The environment was not stimulating for people to be able to engage in any activity. There were no objects to encourage people to stop and read or stop and do something linked to their previous occupations.

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.

This is the first inspection for this newly registered service. This key question has been rated Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- Staff rotas had not been planned to enable staff to have time to sit with people and involve them in their care. Whilst we observed on one day of our inspection two staff did have some time to talk with people, they were inexperienced and had not had training in dementia. This meant they struggled to find ways to involve and engage with people. One member of staff told us, "We do have time to sit in the afternoons sometimes and talk with people, but we need to do better than just manage."
- Care plans had a 'named nurse' or a key worker assigned to a person. When we asked people who their key worker was they did not know they had one. A key worker can support people to express their thoughts, views and preferences for how they want their care to be delivered.
- There was a lack of evidence in people's care plans to confirm they were involved in the care planning process.
- Since the manager had commenced their position in October 2019 there had been one 'residents meeting'. The manager told us they had one booked for the week after our inspection and planned more. However, this was not everyone's preferred method of sharing their views. One person told us, "We have had residents' meetings in the past, I find it too overwhelming to stand up and say things in front of everyone." No other format of gathering views and helping people to be involved had been considered that we were told about. The manager told us they planned to have more regular meetings and develop the key worker system to help people share their views.

Respecting and promoting people's privacy, dignity and independence

- People's records were not always stored securely. We observed whilst care plans and daily records were electronic, some paper records were left in public areas.
- We raised concerns with the manager about the privacy, dignity and independence of one person whose bedroom was without curtains. The person had repeatedly pulled the curtain pole off the wall, and they were without curtains for three days prior to the inspection. This had impacted their quality of sleep and wellbeing. Records stated, '[Person] went to her room, came back because the curtains are still not put up since yesterday, reassured that [person] can sleep in another room for tonight. A sleepless night followed with [person] sleeping in the lounge or walking the corridors'. The manager told us they would need to look into suitable alternatives for the person. The person's bedroom faced the car park and staff told us the person was supported to dress in their bathroom for their dignity. The manager told us they had arranged for the curtain pole to be put back up on the day of our inspection.
- People's independence was encouraged and supported by staff. People were supported to eat and drink independently. Staff told people what was on their plate. They also guided people with visual impairments

as to where cutlery and drinks were. Some people were also supported to manage their medicines independently. One person told us, "I want to keep my independence as long as possible, I manage my own medicines."

Ensuring people are well treated and supported; respecting equality and diversity

● People's personal histories and information on their backgrounds had not always been sought or recorded. When supporting people with dementia having this information can help staff gain a better understanding of people's needs.

● People told us they were being cared for by staff who were kind and caring though rushed at times. Comments included, "Staff are quite nice, though they are rushed", "Very nice staff here, they tell me they have got too much to do", "Staff are good and have been kind" and "Staff are kind and caring, I am struck by their patience with others."

● We observed some kind and caring interactions, where people were supported by staff who were polite and friendly. We saw one staff member engaging a person in conversation about where they had lived, their family life and career highlights.

● Staff from different roles were quick to support people and worked together as a team. We saw housekeeping staff making people hot drinks, chatting and helping to direct people to the bathroom or their bedroom.

● Relatives we spoke with told us they could visit when they wished. One relative told us, "I visit when I want, there are not restrictions. Staff are wonderful with their greeting, it is a family feel here."

Requires Improvement

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 Requires Improvement. This meant people's needs were not always met.

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

- People's care plans and records were not personalised and lacked details. This meant the provider could not be sure people had received the support they needed.
- One person was recorded as being 'very upset' or 'agitated', as well as displaying physical behaviours staff found difficult to support. There was a lack of evidence about what actions the staff took to support the person so the service could not be sure the staff had used the correct approaches.
- People's daily records were task focussed and contained entries which did not relate directly to the person. For example, there were frequent entries where staff stated they were 'providing care to other residents.' We also saw one entry which showed a person's weight was not recorded, 'due to insufficient staff to complete the task.'
- People at risk of dehydration did not have records to demonstrate they had been given sufficient fluids. Records for people at risk of malnutrition, with an assessed need to have their food intake monitored were not well-maintained.
- People's end of life wishes had not been recorded in their care plans so staff would know how to support people at this stage of their lives. The manager told us they recognised this and was now starting the conversation with people during the pre-admission assessment process.
- We were advised one person was receiving end of life care and support, however their care plan had not been updated to reflect this. This meant the person was at risk of receiving inconsistent care. They were being supported by staff who would not have access to assessments of the person's current needs.
- The manager told us they knew end of life care planning needed to be improved. They told us one person had passed away in the weeks prior to the inspection. The manager had needed to have sensitive conversations about end of life wishes, after the person had passed away.

Whilst we saw no evidence of harm the provider had failed to make sure they had an accurate, complete and contemporaneous record for people using the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests

- The home employed two activity workers who planned and carried out most of the activity provision at the home. One activity worker was on long term absence which left one member of staff planning and carrying out activity for the whole service.
- People living on the first floor had very little activity to occupy them or engage them in meaningful occupation. We observed one person walk up and down the corridors looking for how to get out to "go

home". Staff tried to distract them by asking them to come and sit down or have a drink. This response appeared to make them more agitated.
● There was an activity programme in place and people from both floors of the home could come together for these. The activities in the week we visited included potting plants, quizzes, movie showings, and a guest speaker. We saw people were out using the garden for walks and able to go out with their relatives for trips out into the local community.
● People told us they were offered to join in the activities that were planned. Comments about the activities included, "Don't mind the activities there is enough going on for me" and "Always activities going on."
● The activities worker told us they would prepare and leave activities such as puzzles and games for people.
● People who spent time in their rooms or were cared for in bed were visited by the activity worker for one-to-one social time.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● People's care plans contained information about their communication needs. For example, whether they required hearing or visual aids. This meant staff knew what support people needed to ensure they were able to communicate well.
● The provider had documents available in a range of formats to help people understand information. For example, there was an easy read complaints procedure.

Improving care quality in response to complaints or concerns
● People told us they would complain if needed to the manager but were not confident of the process. Relatives we spoke with told us they would complain to the manager if they needed to. One relative said, "I know who the manager is I would complain to them."
● There was no guidance for people available around the home. The regional manager told us they would make sure a complaints process was put up on notice boards for people to view.
● Complaints that had been received had been logged and investigated.

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.

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

- The service was not well-led. There had not been a registered manager in post since June 2019. Despite this being a new service, there had been a number of managers since the previous registered manager had left their post, but none had completed their registration with CQC.
- At the time of our inspection, there was a manager in post who had applied to be registered with CQC. They were being supported by a regional manager who visited at least monthly.
- People were not receiving person-centred care which enabled them to achieve good outcomes. People told us they had to wait for care, that they did not see any point in complaining as nothing was done and they were not involved in their care. Comments from people included, "Nothing happens so there is no point in complaining", "I am in two minds about liking it here" and "I haven't seen my care plan."
- Staff told us they did not think the home was being well managed by the current manager. Comments about the manager included, "We need a manager that everyone can get on with. My colleagues tell me he is rude to them", "The manager's way is the right way, he is not open to other voices. He is also not great at doing good communication or handover" and "We have a new person moving in today, nobody knew about this until today, the manager did not tell us."
- Staff told us they did not feel valued by the provider which had left them feeling de-moralised. Comments included, "I feel very undervalued, I am a number on a spreadsheet, that is our identity. We have been expected to break ourselves to cover shifts. Some staff have broken themselves to keep things afloat" and "I don't want to come in some days, it is not a nice atmosphere. The way it is run with not enough staff, so we get put on. The big bosses came to visit one day, we were told to stay out of the way."
- People and staff told us there was a high turnover of staff. Comments included, "Seems a continual change of staff you don't get any continuity", "There is a high turnover of staff, they earn more at [local supermarket]. One girl only lasted one day, they have too much to do" and "I can't lie and say morale here is good because it is not. Turnover [of staff] has been ridiculous, so many people coming and going, that takes its toll."
- The manager did not always appear to take accountability for their managerial responsibilities. For example, staff informed the manager they were short of staff on nights. One member of staff had written in a handover book they had told the manager they were short staffed. The manager had told the staff to "top and tail". We asked the manager what this meant. The manager told us this meant one member of day staff to stay on duty till 10pm and the next day another to come in at 7am. This would help the night staff as they were understaffed. This did not provide safe staffing numbers from 10pm to 7am. This placed people and

staff at risk of harm.
● When we provided feedback about staffing levels, the manager apportioned blame to the staff team for their perception of being short staffed. They said, "It is a state of mind", rather than advising us how they planned to work with the staff team to address how they felt. The manager told us they had informed staff not to tell people if they were short staffed as this would worry people. This gave us no indication the manager would review staffing numbers.
● The manager stated they would not attempt to resource agency staff. This was due to the manager's pre-set perceptions about agency staff availability. This attitude placed people and staff at risk of harm.
● There was a difference between what the provider believed to be sufficient staff numbers and staff and people's experiences, which were not positive. One person told us, "It is generally a nice atmosphere here, but I worry about staffing."
● People told us they had to wait at times for staff to answer their call bell. The manager told us they were not able to monitor call bell response times as the system was broken. They hoped to have this fixed soon. The regional manager told us they would expect the manager to carry out spot checks on the response times, this had not happened.
● Another managerial responsibility was monitoring people's weights. When asked whose responsibility it was, they said, "My predecessor." This was despite having worked at the home for four months. They advised us they would address this shortfall and implement a broader oversight system within the two weeks following the inspection.
● There was a lack of managerial oversight of how records were completed. We asked one staff member if they knew who was responsible for ensuring thickener records were maintained. They did not know if the records were checked and told us everyone knew they should be filling them in. The handover books were being inconsistently used with no visible action being taken to address shortfalls.
● The home did not have a 'care office'. Whilst the provider' records were electronic there were some paper records in use. We found records in the kitchen areas of the home on both floors left unattended. This meant people's confidential information was not stored securely.
● Systems were in place to monitor the service and identify improvements. The provider's quality teams were visiting the service every three months to carry out quality audits due to the rating they had achieved. In October 2019 the service had been rated 'Inadequate' by the internal quality team's audit. In January 2020 the service was still rated the same, not enough improvement had been carried out.
● The service had an action plan which the manager and the provider could access. Some actions had been completed but there were still many actions outstanding to make sure the home was compliant. We were not able to see that enough resources were available to make sure this service could carry out the required improvements.

The provider did not have systems or processes in place to assess, monitor and improve the quality and safety of the service and did not ensure records were maintained securely. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People's views had been sought using a questionnaire in 2019. Results determined that people were 100% overall happy with the service. We found however, that people were not always happy with the care received at the time of our inspection.
● Care reviews had not always been carried out to give people the opportunity to discuss their care. A care review helps people to identify what is working well and what needs to change, if anything. One relative told us, "We have been here four months we have not had a review that we know about."
● Staff were not being encouraged to share their views about the service. They told us they had tried to

approach the manager to raise concerns but found he was not responsive or wanting to listen. For example, one member of staff had been asking the provider for laundry bins to move wet laundry to the tumble dryers for eight months. We saw in meeting minutes and supervision records staff continually ask for this equipment. We checked in the laundry room and found the equipment was not available. We asked the manager why this equipment had not been provided. They told us they were struggling to find the equipment but would seek advice.

● The provider had carried out a staff survey and the results were shared with staff in a staff newsletter in January 2020. Results found 90% of staff enjoyed their role and 96% of staff knew what is expected of them at work. These results do not correspond to the comments we have heard from staff working at this service.

Working in partnership with others

● The service worked in partnership with other agencies to provide people with the healthcare they needed.

● The manager told us they tried to establish links with the local community. They had encouraged a school to visit weekly which people seemed to enjoy.

● The manager had started a monthly community coffee morning to encourage the local community into the service. There were also links established with local services for people living with dementia.

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 11 HSCA RA Regulations 2014 Need for consent The provider had failed to make sure care and treatment was provided with the consent of the person or relevant person. Regulation 11 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to assess and manage risks to the health and safety of people. The provider had failed to always manage medicines safely. Regulation 12 (1) (2) (a) (b) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure good governance systems to enable them to assess and improve the quality and safety of the service provided. In addition, the provider failed to maintain securely accurate, complete and contemporaneous records for each person. Regulation 17 (1) (2) (a) (b) (c) (d) (ii)

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 failed to ensure there were sufficient staff deployed to safely meet people's needs. Staff were not always skilled to meet people's needs or receiving appropriate supervision.

Regulation 18 (1) (2) (a)