

ADR Care Homes Limited

# Bethany Francis House

## Inspection report

106 Cambridge Street  
St Neots  
Cambridgeshire  
PE19 1PL

Tel: 01480476868  
Website: [www.adrcare.co.uk](http://www.adrcare.co.uk)

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## Ratings

Overall rating for this service

Inadequate ●

Is the service safe?

Inadequate ●

Is the service effective?

Inadequate ●

Is the service caring?

Inadequate ●

Is the service responsive?

Inadequate ●

Is the service well-led?

Inadequate ●

# Summary of findings

## Overall summary

About the service: Bethany Francis House is a residential care home that was providing accommodation and personal care to 16 people aged 65 and over on the first day of the inspection and to 15 people on the second day.

People's experience of using this service:

People's experience at Bethany Francis House was poor. There continued to be widespread systemic failings at the service despite the continued support from the local authority safeguarding and quality monitoring teams to mitigate risk to people using the service. Continued failure in the provider's understanding in their legal responsibility to ensure adequate staffing levels and training, and an environment that is fit for purpose, clean and hygienic has continued to impact on the quality and safety of care delivered to people at Bethany Francis House. Lessons had not been learned to minimise reoccurrence of risk and drive improvement effectively.

Inconsistent management and leadership has led to a failure to address recurring risk to people's safety and welfare, and to drive and sustain improvement. The provider did not have any systems or processes in place that were effective to identify and manage where things had lapsed or were going wrong.

There were not enough staff to meet the needs of people, respond to them in a timely way, maintain their dignity and keep them safe. Due to insufficient staffing numbers people had to wait to go to the toilet and were left for long periods of time, unsupported and unsupervised.

People were not provided with regular access to activities that were meaningful and appropriate to their needs, to promote their wellbeing and protect them from social isolation. Care was mainly based around completing tasks and did not take into account people's preferences, choices, abilities and strengths. It was not planned or individualised and did not promote independence, where possible. Care records provided insufficient guidance for staff in how to provide care and support to people that was appropriate to their needs and minimised risk to their health and wellbeing.

Staff worked very long hours, and on occasion double shifts, to ensure shifts were covered and ensure people received care from staff they knew and trusted. However, staff were tired and unsupported by the provider; this had caused some to become sick, and others to leave.

Staff were not suitably trained. People were not cared for and supported at all times by staff who had the right knowledge, skills and competency to carry out their roles properly and safely. Staff did not always respond to safeguarding concerns in a safe way and they had limited or no understanding of how dementia affected people in their day to day living.

The home required significant redecoration and repair and many areas of the home were unhygienic and unsafe. There continued to be significant risk around fire safety and water safety. The environment had not

been adapted to meet people's diverse needs and did not promote a dementia friendly environment. There were no suitable bathing or showering facilities for people to have a bath or shower safely and comfortably. Corridors were dimly lit.

Rating at last inspection: The service was rated Inadequate at the last inspection and placed into Special Measures. The report was published on 6 November 2018. For more details please see the full report on [www.cqc.org.uk](http://www.cqc.org.uk).

Following the last inspection, we sent an urgent action letter to the provider telling them about our findings and the seriousness of our concerns. We asked them to complete an urgent action plan telling us what they would do and by when to improve the key questions safe, effective, caring, responsive and well-led to at least 'Good.' We took immediate enforcement action to stop further admissions to the service and force improvement.

Why we inspected: We inspected in February 2019 because the home was in special measures which means we must return within six months to check the service again. We were aware before this inspection of continued concerns raised by whistle blowers, relatives and local authority.

Enforcement: 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 of this service is Inadequate and the service therefore remains in special measures. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

For more details, please see the full report which is on the CQC website at [www.cqc.org.uk](http://www.cqc.org.uk)

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Inadequate ●

The service was not safe.

Details are in our Safe findings below.

### Is the service effective?

Inadequate ●

The service was not effective

Details are in our Effective findings below.

### Is the service caring?

Inadequate ●

The service was not caring

Details are in our Caring findings below.

### Is the service responsive?

Inadequate ●

The service was not responsive

Details are in our Responsive findings below.

### Is the service well-led?

Inadequate ●

The service was not well-led.

Details are in our Well-Led findings below.

# Bethany Francis House

## Detailed findings

### Background to this inspection

The inspection: We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted in part by on-going concerns shared with the CQC, since the last inspection on 10 and 17 September 2018, by the local authority and whistle-blowers.

Inspection team: An inspection manager and inspector carried out this inspection.

Service and service type:

Bethany Francis is a 'care home.' People in care homes receive accommodation and personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, both were looked at during this inspection. The care home accommodates up to 34 older adults, including people living with dementia, in one adapted building over two floors.

The service has been without a registered manager since 25 July 2018. A registered manager 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. This meant that the service did not know we were coming.

What we did:

Prior to this inspection we reviewed the information we held about the service, including notifications. A notification is information about events that by law the registered persons should tell us about. We looked at feedback from the local authorities monitoring visits of the service of people's care. This was to find out their views on the quality of the service. We used information the provider sent us in an action plan following our inspection in September 2018 telling us about the improvements they were making to address breaches of regulation and meet conditions imposed on their registration.

During the inspection, we looked at various information including:

- ☐ Care records for four people.
- ☐ Looked at four staff files including all aspects of recruitment, supervisions, and training records.
- ☐ Looked at health and safety, servicing records and risk assessments.
- ☐ Looked at records of accidents, incidents and complaints.
- ☐ Looked at audits and surveys.
- ☐ Looked at people's medicines management.
- ☐ We spoke with two people using the service, two staff, the maintenance person, the deputy manager, home manager (of six weeks) and the operations manager (of one week).
- ☐ We took photographic evidence of environmental and maintenance concerns.

# Is the service safe?

## Our findings

We have inspected this key question to follow up the concerns found during our previous inspection on 10 and 17 September 2018. Those concerns related to staff who did not ensure people were kept safe from harm or fully understood what constitutes a safeguarding. Effective systems were not in place so that risks to people's well-being were not consistently identified or met by staff. Potential new staff recruitment checks were insufficient. Fire prevention and precaution measures and staffs fire training were not satisfactory. People were not protected from the unsafe management of their medicines and there were not enough suitably trained staff to provide the right level of care and support people needed on each shift. The premises and equipment was not sufficiently cleaned or maintained. At this inspection, the provider had not made the required improvements. We have judged this rating as a continued, 'Inadequate.'

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

Inadequate: People were not safe and were at risk of avoidable harm. Some regulations were not met.

Systems and processes to safeguard people from the risk of abuse

- The provider did not recognise or understand the wider aspects of safeguarding people from risk or harm as identified in this report.
- Concerns had continued to be found during local authority monitoring visits which required investigation such as night staff sleeping on duty.
- People who expressed their frustration and anxieties through their behaviours were not effectively supported. Positive actions were not planned for or put into practice when staff were faced with difficult situations that could potentially compromise safety.
- The provider did not have enough staff to ensure people were protected from disinhibited sexual behaviour.

Assessing risk, safety monitoring and management

- The provider had not fulfilled their responsibilities in relation to checking premises and equipment, and identifying hazards that may pose a risk to people. There were no current or recently reviewed risk assessments relating to health and safety, fire safety and water safety.
- The last fire risk assessment was carried out on 5 September 2016; this assessment considered the risk to life from fire at this building was high. The provider had still not completed all of the recommendations some two years after the assessment was carried out and the assessment had not been fully reviewed and risks re-assessed since. We found rooms full of combustible material that posed a significant fire risk. We also found electric plugs and wiring that posed a fire risk.
- Service user's personal emergency evacuation plans (PEEPs) were carried out by a person who lacked skill, experience and training. The PEEPs were completed in January 2019 by a designated member of staff who had no knowledge of individuals health and medication needs to make an accurate assessment of the right level of support they would need in an emergency evacuation, particularly at night.

- Moving and handling practices were not managed safely and people were at risk of potential harm or injury.
- Two staircases were accessible to people, wandering independently but unsteady on their feet and lacking capacity to recognise the risk of using the stairs alone. The risk had not been identified and assessed to see if any action should be taken to mitigate the risk to people.

## Preventing and controlling infection

- The laundry facilities were not designed or maintained to minimise risk of recontamination and therefore people and staff involved in the handling of used and soiled linen were not protected from the risk of cross infection. Specific hygiene measures were not taken to reduce risks including keeping the laundry room clean, the correct handling of laundry to prevent spread of infection and decontamination of laundry. Wall surfaces of the laundry room were damaged with peeling paint, permeable and did not allow for effective cleaning.
- There were no sluice facilities or equivalent for the emptying cleaning and disinfecting of commodes and no cleaning schedule in place for commodes. Staff were unable to demonstrate that commodes had a weekly deep clean to reduce the risk of cross contamination.
- There was only one sink in the laundry room which was corroded and unclean and this was used for the emptying and cleaning of commodes. There were no separate hand washing facilities nor a soap dispenser or paper towels available in the laundry room for staff to wash their hands and prevent the risk of infection and cross contamination.
- The Environment Health Officer found on 4 February 2019 the kitchen did not meet hygiene standards. No action had been taken to address this with a deep clean. Walls and floors were filthy with grime and grease, air vents and fly screens were clogged with dead insects, grease and dust and mould growth around the sink and windows. Extractor fans were not working and had not been serviced or maintained. Staff told us the dishwasher was not working and hadn't been for some time. It was not washing properly or reaching the correct temperature.
- There were no mattress checking and cleaning schedules in place. We looked at mattresses in all used bedrooms and saw they were old, stained and we could feel the springs through the mattress tops. There continued to be a failure to recognise the importance for everyone at the service to have a clean and comfortable mattress to support wellbeing and dignity. This increased the risk to people re the potential implications for the risk of cross infection.
- A relative had complained and expressed shock at the state of their family members room including stained and soiled mattress and flooring.
- The management of the risk Legionella had not been monitored effectively to safeguard people living and working in the service coming into contact.

This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

## Staffing

- There were not enough staff to provide the right level of care and staff were not deployed in a way that ensured people's safety and dignity. We saw a staff member feeding two people at the same time. People were left unsupported and unsupervised for long periods of time. We found one person placing themselves and another at risk of harm because they were piling furniture on top of one another. We had to intervene.
- Staff told us that some staff were working excessive hours to make up the allocated numbers. On the day of our inspection there were only two staff on the rota to cover from 8am to 2pm, another staff member was called in and arrived at 10.30am. A staff member told us that they had worked up to 70 hours one week to



ensure people received care. Tiredness from working excessive long hours could affect the quality of care delivered and the safety of people's care.

- Records showed and staff told us that the numbers of staff, particularly on nights were not consistent and on some nights, there were only two staff to care for everybody. Revised dependency levels showed that 11 out of 16 people had 'high risk' and complex needs. Staff told us eight people needed the help of two staff to move. People who cannot communicate their needs or use call bells rely on frequent checks. We received a notification prior to this inspection telling us the only two staff on duty were found asleep, one night in January, placing people at potential risk of harm.
- The manager and staff confirmed there continued to be no care staff who held substantive contracts of employment. Staff on zero-hour contracts are not obliged to come in for shifts. The manager and senior told us that the rota was impossible to manage because there was no team. There was no contingency plan to remedy unforeseen staff absences. There were only two permanent part time night staff. There was a heavy reliance for temporary agency staff to cover night shifts.
- When rostering the agency staff to work shifts, there were no checks made to make sure at least one staff member working had been trained in fire safety and first aid. We found there were none of the staff rostered for the night duty had received recent training in fire safety and first aid, and their competencies had not been assessed. This meant people were at risk during the night if there was a fire or if they needed first aid. To mitigate this risk a senior carer followed their 12-hour shift with a sleep-in duty to provide the skills required if needed.

This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

#### Learning lessons when things go wrong

- There was no formal system or process in place that ensured each safeguarding concern, complaint or incident was reviewed and ensured action was taken to remedy the situation, protect people, prevent re-occurrence and make sure that improvements were made as a result.
- There was no record of actions and lessons learned taken forward from recent events.

#### Using medicines safely

- Despite improvement made to the storage and security of medicines and following the correct procedures when administering medicines to people who lack capacity without their consent; further improvement was needed.
- Not everybody prescribed 'as and when required' medicine had detailed guidance for staff in place on when it should be administered, for example a laxative for constipation.
- We were notified by the local authority monitoring visit that medicines were being administered by a staff member who had not been trained or competent placing people at risk of harm from potential error.
- There was not always a staff member trained and competent to administer medicines at night which meant if a person required pain relief they would either not get it or it would be delayed until a trained staff member could get there.
- Many people with dementia related needs were unable to communicate their pain or request pain relief. There were no methods or tools in place to help staff gauge and monitor people's pain to ensure adequate pain relief is given.

# Is the service effective?

## Our findings

We have inspected this key question to follow up the concerns found during our previous inspection on 10 and 17 September 2018. Those concerns were in relation to poor training, support and development for staff which meant some staff were not competent to provide safe and appropriate care to people. The premises were not well maintained, clean or enabling for people to live in. The principles of Deprivation of Liberty Safeguards (DoLS) had not been fully considered for people living in this service. There was a lack of understanding from staff about safe and effective covert administrations of people's medicines. At this inspection we found the provider had not made enough improvement and have judged this rating as a continued, 'Inadequate.'

**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

**Inadequate:** There were widespread and significant shortfalls in people's care, support and outcomes. Some regulations were not met.

**Staff support:** induction, training, skills and experience; delivering care in line with people's assessed needs, standards, guidance and the law.

- Pro-active support for staff learning and development continued to be insufficient. People were receiving care and support from staff who did not always have the skills and competency to carry out their role.
- There was a high turnover of staff, many new starters not having worked in care before. There were no systems or processes in place to provide new staff and temporary staff with effective induction training, support and continued competency assessment. Newly employed staff, one had started in October 2018, confirmed they had not commenced The Care Certificate; a nationally recognised programme and assessment to support staff in gaining an understanding of the fundamentals of care and standards they should be working to.
- Training was not tailored to individual needs and learning styles. Training and refresher training in core relevant subjects was delivered via e-learning over one day which meant it was unlikely this method encouraged effective learning. There were no systems in place to check how effective the training was.
- Practical moving and handling and more substantial safeguarding training was rolled out following our last inspection however some staff were still not recognising poor practice or understood the impact this had on people.
- Staff training was not developed or delivered around individual needs. People using the service had needs associated with long term conditions such as diabetes, Multiple Sclerosis, Huntington's Chorea and End of Life Care. Without training specific to the needs of people this increased the risk that staff may give care that was inappropriate and/or unsafe.
- People using the service were at various stages of their dementia condition ranging from early onset to advanced stages. Staff had a limited or no understanding of how dementia affected people in their day to day living, due to a lack of training. Skills in communication, person centred care, diversity and engaging with people in purposeful activity were lacking.

- A staff member, recently appointed to provide social care within the home, had no previous experience in this role and had not received any training to support them in relation to the wider aspects of dementia; how to provide meaningful engagement and activity suited to individuals specific cognitive and physical abilities.
- The staff member, tasked to manage the premises were not instructed and trained, competency assessed or supported, to carry out health and safety responsibilities in the home. Checks in place were not comprehensive enough or based on nationally recognised health and safety requirements.
- Staff were not receiving regular supervision or appraisals to support them in their roles and effectively review practice.

This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The layout and decoration of the home was not conducive to the needs of people living with dementia. Staff who had previously received some training in understanding dementia told us they recognised the home is not set up to ensure care given is appropriate or reflected best practice.
- The service continued to lack dementia signage and decoration to help support people with visual clues to navigate their way around the building, and promote interest. The provider had not used prime colours for definition and enable people to distinguish for example hand rails and toilet doors.
- Corridors, bedrooms and communal areas were dark and dimly lit posing a risk to people with poor eyesight or for those with dementia experiencing hallucinations.
- Additional lighting was provided in the main corridor by two heavy metal lamps. The lamps were fixed to a piece of hardboard and screwed on to the hand rail. They were insecure and posed a risk of harm and injury to a service user if they grabbed it for stability instead of the hand rail.
- Staff told us they recently had to condemn and dispose of several black bin bags of stained and threadbare bedlinen. We saw the linen room lacked an adequate number of spare sheets with only three flat sheets and four fitted sheets available. When we returned on 21 February 2019 the provider had replaced five fitted sheets and ten flat sheets. This is still not enough to ensure there are enough sheets to meet the needs of 16 people with continence needs.
- The bathrooms and shower room throughout the home were unfit for purpose. They did not have sufficient space to accommodate two staff and moving equipment needed by people with limited mobility to transfer. The baths were too low and short for people to use, one being a domestic corner bath. Auto lift and bath locking mechanism did not work on either bath chair hoist.

This was a continued breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- People's lunchtime experience had improved since our last inspection but further improvement was needed to achieve a meaningful experience.
- People were offered a choice of meals and desserts but this was done a long time before meals and verbally. This for most people was meaningless because they could either not process the information or remember it. Visual prompts or objects of reference were not given to prompt and support people's choice.
- The cook did not have the correct equipment to provide the correct textures of food as recommended by healthcare professionals for five people with swallowing difficulties. Staff told us that repeated requests

from the kitchen to the provider for a liquidiser were not granted until February 2019. There were no moulds for softened/pureed foods to help resemblance of the original form.

- Jugs of juice and beakers were placed in communal areas, but this was not effective because people did not get up to help themselves. For some people they did not drink unless prompted and this did not happen regularly because there was not enough staff to supervise people seated in communal areas.
- Hot drinks were brought round mid-morning and mid-afternoon. Staff offered snacks of cakes and fruit to people, at these times.

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

- Local authority monitoring visits have provided oversight of people's health and welfare and ensured prompt referral to relevant healthcare professionals when needed.

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 with appropriate legal authority. 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 any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

- As an outcome of the local authority monitoring visits a DoLS assessor had recently reviewed applications for people who lacked capacity. From this new or renewed applications would be sent to the local authority supervisory body to deprive people of their liberty in a lawful manner.

# Is the service caring?

## Our findings

We have inspected this key question to follow up the concerns found during our previous inspection on 10 and 17 September 2018. Those concerns related to people not being treated with dignity and respect. We have judged this rating as Inadequate.

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

Inadequate: ☐ People were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls and some regulations were not met.

Respecting and promoting people's privacy, dignity and independence

- The provider had not ensured the service was run in a manner that promoted a caring and respectful culture. There were significant shortfalls as shown throughout this report about the standard of furnishings, mattresses and bed linen and the poor upkeep of the home which did not promote or respect people's dignity.
- Staff told us there was a lack of personal care items for people such as towels. The local authority raised concerns that people were not receiving mouthcare. People did not have denture pots to soak and store dentures overnight. Towels, soap and in some cases toilet paper were absent from ensuite and toilet facilities.
- Due to the lack of staff some people were left in an unhygienic and undignified manner before they could be supported with their toileting needs. Staff did not support people routinely or regularly to go to the toilet.
- Staff told us that they were unable to bath or shower people because the facilities were not adequate to meet their needs.
- Staff told us there was a culture to get people up very early in the morning and put them to bed early in the evening despite their choice and preference.

This is a continued breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring people are well treated and supported; equality and diversity

- Staff showed kindness and compassion to people but the provider did not recognise or value this. The provider had not encouraged a culture to support staff efforts alongside appropriate knowledge and resources, to help staff understand the needs of people and how they should be cared for.
- Staff told us that they brought toiletries in for people because there were no resources or arrangements in place for this.
- Staff told us they brought in their children's books and puzzles to help occupy people's time because there were no resources provided.
- There were not enough skilled and competent staff to effectively meet people's diverse needs and limit

their distress.

- Staff did not use accessible means of communication to enable people to express their choice and preference.

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

- People were not supported to express their views or be involved in making decisions about their care.

# Is the service responsive?

## Our findings

We have inspected this key question to follow up the concerns found during our previous inspection on 10 and 17 September 2018. Those concerns related to people not receiving care that was personalised and planned to meet their specific and individual needs. At this inspection, provider had made some but not all of the required improvements. We have judged this rating as a continued, 'Requires improvement.'

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

People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

- Care and support was not planned and delivered in an individualised or personalised way. Staff told us due to being short of staff they were unable to provide care that was person centred and could not achieve good outcomes for people.
- Some care plans were revised after our last inspection but had not been regularly updated since. Some were no longer relevant and current, particularly where people's needs had deteriorated. Care staff were not part of this process.
- The service did not meet people's individual needs in relation to maintaining interests, hobbies, contact with the community or meaningful occupation.
- Two people were observed to wander continually around the service during both days of our inspection. Staff did not provide consistent or effective support to these individuals and their experience of day to day living at the service was poor.
- One kept asking staff what were they to do? and where were they? Staff told them repeatedly there was nothing for them to do because they were retired and just took the person back to their room. Ten minutes later they would be back asking staff the same questions with the same outcome, the person was very distressed.
- Six people were observed sat at tables throughout the morning, disengaged staring down at puzzles or books placed in front of them. There was no thought given to the relevance of the puzzles or books according to the individuals wishes, preference and abilities. The activities were not age appropriate; the themes were children's fiction.
- We observed one of these people remained seated at the dining table from 8am to 5.45pm, only got up to go to the toilet. No meaningful interaction or stimulation was given.

Improving care quality in response to complaints or concerns

- The providers complaints policy was on display on the communal notice board in the entrance of the service for people and their visitors to refer to if needed.
- The complaints system has been managed inconsistently with no evidence of learning applied to practice.

End of life care and support

- There was no recognition that a diagnosis of dementia, Alzheimer's or Huntington's Chorea is a terminal disease. Staff were not trained in end of life care.
- Care and support provided is task -centred rather than planned and in response to people's changing needs and end of life needs and preferences.



# Is the service well-led?

## Our findings

We have inspected this key question to follow up the concerns found during our previous inspection on 10 and 17 September 2018. This was because we found widespread and significant shortfalls in the way the service was managed with regulations not being met. The provider had failed to give effective oversight of the service which had led to a failure to address recurring areas of risk to people's health, safety and welfare. At this inspection, the provider had not made the required improvements. We have judged this rating as a continued, 'Inadequate.'

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

Inadequate: ☐ There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Managerial arrangements have been extremely unstable and this has had a direct impact on the quality and safety provided. The last registered manager left in July 2018. Since, there has been a turnover of four home managers and three operational managers, as well as input from external consultants.
- The varied managerial input and lack of provider support has failed to develop a consistent infrastructure needed to affect and drive improvement. This meant clear and effective governance systems and accountability arrangements were not developed, embedded and sustained.
- The lack of continuous leadership has resulted in no structure or direction for the staff team. They were unclear on their roles and responsibilities. The provider did not provide staff with regular support and guidance to enable them to effectively carry out their role, which meant they were not recognising or managing risks.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

- The delivery of high quality person centred care was not assured by the leadership, governance or culture in place at this service.
- The provider was out of touch of what is happening in the service

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

- Engagement with people, staff, the public and community is minimal.
- The culture of the service was not open, transparent or inclusive. Staff told us they felt devalued; there was no positive engagement from the provider, only a blame culture.

- The provider had no systems in place to check if people's life and experiences of living in the home could be improved upon in any way.

#### Continuous learning and improving care

- Despite the service being in special measures the provider has not had an effective plan for improvement. The focus on improvement was almost entirely reactive on a day to day basis.
- The provider has given no regard to safeguarding concerns or complaints. There was a continued failure to learn lessons from incidents that effect the health safety and welfare of people, and share with staff. There was no formal system or process in place that ensured incidents were reviewed and monitored to make sure that action was taken to remedy the situation, protect people, prevent further occurrences and make sure improvements are made as a result.
- Staff turnover was high and staff were not adequately supervised.

#### Working in partnership with others

- The service does not promote opportunities for people to go out into the community.
- There was no engagement with other organisations, agencies or networks to share best practice, expertise or resources to improve the service and deliver a good experience of care for people.

This is a continued breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.