Abbey Healthcare (Cromwell) Ltd

Cromwell House Care Home

Inspection report

82 High street
Huntingdon
Cambridgeshire
PE29 3DP

Tel: 01480411411
Website: www.abbeyhealthcare.org.uk

Date of inspection visit:
02 August 2022
08 August 2022
12 August 2022

Date of publication:
25 April 2023

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
Cromwell House Care Home is a residential care home providing regulated activities of personal and nursing care to up to 66 people. The service provides support to older people some of whom may live with dementia. At the time of our inspection there were 53 people using the service.

Cromwell House Care Home accommodates people across three separate floors, each of which has separate adapted facilities.

People's experience of using this service and what we found
People gave us mixed feedback about the care and support they received. Some people said they could always ask staff for support and received this, but others told us they were not happy how their needs were met. Some relatives told us they felt the need to visit daily to ensure their family member's needs were met.

Staff told us they had online safeguarding training and had reported concerns but lacked confidence in the registered manager taking action. Not all incidents and accidents were investigated or reported to external safeguarding authorities when the cause of these were not known.

People at risk of developing pressure ulcers, and those with existing pressure ulcers, were not protected from the risk of harm. The equipment in place had not been set correctly to mitigate the risk of people's skin breaking down. There was insufficient equipment available to support people with their mobility. Good infection prevention and control measures were not always followed by staff. This put people at risk of infection and harm.

There were not enough staff to provide people with care that met their needs safely or personalised to their liking. The majority of people were cared for in bed without any clear reason. Relatives told us they needed to visit daily or several times a week to help people with their needs. They said this was because there were not enough staff to provide safe care to people and this worried them. People experienced delays in having their needs met and this had an impact on their health and well-being.

People's needs were assessed prior to them moving into the home. Care plans were developed, however we found numerous examples where records referred to the name of a different person to whom they belonged. Care records did not always reflect people's needs. In some instances, there were delays in referring people to health professionals.

Training was in place for staff, however some training was out of date or not given and the registered manager failed to ensure they checked staff's understanding of the training following completion. Staff told us they had little support from the registered manager. Staff had lost confidence to approach the registered manager with any concerns they may have had due to lack of meaningful action taken in response to previous concerns raised.

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. There were insufficient measures taken by the registered manager, the provider or staff to minimise the impact on people who were solely being cared for in bed. Some people had not been outside of the building since they moved into the home and had not been provided with opportunities to socialise with other people.

A high number of people required assistance from staff to eat and drink. They had not always received this support promptly.

People and relatives told us staff were kind and respectful towards them, however they were always in a rush and at times their actions had not demonstrated a caring approach. Some people were washed and then dressed in their day clothes in the middle of the night. They were then left in bed to continue sleeping whilst fully dressed. Some people told us staff had not always listened to what they wanted.

The registered manager and provider failed to ensure people received care and support in a personalised way. Staff worked in a task led manner which led to institutionalised practice of providing support for people when it was their "turn". There were some activities and opportunities for engagement, but these were limited at the time of the inspection.

Systems were not effectively operated to provide safe care to people. The provider's quality and assurance processes were not used effectively. Audits carried out by the registered manager failed to identify areas in need of improvement. Where the provider identified areas in need of improvement through their own audits, they had failed to ensure the improvement actions needed were completed and ensure people's experiences improved.

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

Rating at last inspection
The last rating for this service was good (published 15 November 2018).

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

The inspection was prompted in part by notification of an incident following which a person using the service sustained a serious injury. 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 CQC received about the incident indicated concerns about the management of skin integrity and risk assessments. This inspection examined those risks.

You can see what action we have asked the provider to take at the end of this full report.

The provider took some immediate actions to ensure people were safe and they received care and support effectively. Actions included increase in staffing, ordering new equipment and involving health and social care professionals in re-assessing people's needs.

Enforcement

We have identified breaches in relation to safeguarding people from abuse safe care and treatment, staffing, personalised care, dignity and management of the service 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
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 alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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

If the provider has not made enough improvement within this timeframe, and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not always 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.

Cromwell House Care Home

Detailed findings

Background to this inspection

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

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

Inspection team
This inspection was carried out by three inspectors.

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

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post.

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
During the inspection we spoke with ten people who used the service, four relatives, four care staff, two nursing staff and the deputy manager. We also spoke with the receptionist, the registered manager, one of the provider's area manager, the nominated individual and the provider's operations director. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke with four health and social care professionals visiting the service on the day of the inspection. 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 looked at seven people's care records and various other documents including accidents, incidents and medicine records.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

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

- People did not feel safe and were not protected from the risk of abuse. The registered manager and the provider failed to identify on some occasions where safeguarding concerns needed to be investigated or reported to local safeguarding authorities. One person said, "I don't always feel safe." One relative told us, "I am extremely worried all the time. It's not always safe here."
- Staff told us they had received training around identifying abuse and how to report to management, however they lacked confidence in reporting to the registered manager. One staff member said, "I am not confident to approach the [registered] manager. I can talk to the deputy manager, they are good, but I won't talk to the [registered] manager if I have another choice. They don't do anything." Staff were aware of how to report to external agencies through whistleblowing and had done so.
- We found a high number of unexplained and unwitnessed wounds recorded as incidents. The registered manager failed to robustly investigate these and report to local safeguarding authority. For example, one person was found with a bruise on their lip. This did not prompt the registered manager to consider the likelihood of this happening due to unsafe moving and handling. This was despite the registered manager being aware 44% of the staff team had not received face to face moving and handling training. Without a medical review, the registered manager concluded it was due to blood thinning medication. Another person was found with bruising on their arm. The registered manager did not speak with the staff about the bruising, carry out observations of moving and handling, or consider additional training for staff. They concluded again this was due to blood thinning medication and did not consider the risks from poor moving and handling. The lack of safeguarding plans and actions taken by the registered manager or the provider left people at risk of further injuries and harm.
- The registered manager did not reflect on incidents with staff. For example, a recent significant safeguarding concern in relation to poor wound management, was substantiated. The outcome had not been shared with staff to try and prevent this from happening to other people in the home. Staff did not have the opportunity to reflect on their practise and learn valuable lessons to mitigate future recurrence.
- The registered manager did not lead the service in an open and transparent manner with staff when things went wrong. Staff told us, the registered manager blamed them, did not listen to their concerns and did not try to learn lessons to improve care.

The provider and the registered manager failed to operate effective safeguarding processes and learn lessons when things went wrong. This left people at risk of abuse. This was a breach of regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- Risk to people were not mitigated effectively to keep people safe. People developed pressure ulcers due to

a lack of action taken to mitigate the risk of their skin breaking down. For example, people identified as needing staff's support to change their position at regular intervals were not supported as required. One person had been assessed as needing two hourly repositioning. We observed throughout the day of inspection they were not supported to change position. This was confirmed by their relative as well as records.

● People identified as high risk of developing pressure ulcers had air mattresses in place to try and mitigate this risk. However, we found there were no checks in place to ensure these were set for the right pressure according to people's weights. A very high number of mattresses we checked were not at the correct setting. For example, one person whose weight had been recorded as 51.4kg had their mattress set at 160kg. This meant there was an increased risk of them to developing pressure ulcers.

● Risk assessments in place for some people had other people's names in them, therefore the measures listed for staff to mitigate risks were not individualised or at times relevant. For example, the skin integrity care plan for one female person had a male person's name throughout it describing they had dry skin and were prone to bruising. The additional notes in the care plan had a different female person's name.

● Relatives told us they were concerned that risks to people were not always mitigated effectively, for example drinks or call bells were not always left in people's reach. One relative said, "I have seen, as bedroom doors are open, that drinks are not close for people to drink and often people shout as they have no call bells."

The provider and the registered manager failed to assess and effectively mitigate risk to people's health and safety. People were placed at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the feedback we gave to the provider after the inspection, they have taken immediate steps to address some of the most significant risks we identified. They checked all pressure mattress settings and introduced a daily check for these.

Staffing and recruitment

● People, relatives and staff told us there were not enough staff available to meet people's care and support needs. One person said, "They (staff) are not coming (in bedroom) very often. I am left here alone." Another person said, "At night its terrible (staffing). They just don't come. You wait and wait and sometimes the bell is out of reach." The lack of staff was confirmed by relatives who told us they needed to visit almost daily to ensure people were safe. One relative said, "I need to come daily. I need to make sure [person] sits up and then goes back to bed when needed. They are very short staffed and it's no continuity. They use a lot of agency."

● Staffing levels were not always adequate, and the deployment of staff did not always ensure people were supported in a safe manner and had their needs met in a timely way. Staff told us, "We don't have enough staff. We don't have time to talk to people or get around to do everything we should." We observed staff had no time to ensure people were re-positioned comfortably before they were supported to eat their meals. We observed people who had slipped down towards the end of their bed and could not straighten their legs. Some people were laying on their side trying to eat their meals.

● Some people were fully dressed in their clothes, but they were left in bed at times. Staff told us they had no time to get everyone out of bed. Some people had been in bed for months. The registered manager told us on the ground floor alone that, in their view, there were 12 people who could be supported out of bed but due to lack of staff this was not happening.

● Staffing had been raised as a concern in January 2022 to the registered manager and nominated individual. During this time, several staff members including the previous deputy manager had left the service. This did not prompt a review or assessment of staffing or prompt the provider to reduce the

numbers of people living in the service to manage staffing levels safely.
● Records evidenced the lack of staff had a negative impact on people. For example, people were cared for in bed and not supported to sit out and socialise with others, the lack of repositioning at recommended intervals contributed to people developing pressure ulcers and increased risk of dehydration due to lack of support from staff to drink.

The lack of staff to meet people's needs was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider increased staffing following the inspection to ensure people received safe care.

●The provider operated robust recruitment processes. There were pre-employment checks and references in place before staff started working in the home.

Preventing and controlling infection
● On both days of the inspection we observed staff not wearing their masks correctly. A kitchenette area was cluttered, and the sink was unclean and stained. Carpets on corridors were stained and some furniture and fittings were in disrepair. There was work in progress in the home to refresh the environment.
● We observed equipment such as hoists being used from bedroom to bedroom without any cleaning in between. We observed housekeeping staff not following good infection control processes when cleaning including not wearing masks correctly and omitting to disinfect high touch areas like light switches, door handles and handrails. We also observed a staff member walking out of a bedroom and holding a soiled incontinence pad and linen without wearing gloves. They dropped the linen twice in the corridor. When the regional manager told them that they should have used a bag for soiled laundry before they came out from the bedroom, they appeared confused and kept smiling. This meant that good infection control procedures were not embedded in practice and this put people at risk of catching infections.
● Staff stored their personal belongings on a table in the ground floor dining and seating area in the lounge and at the nurse's station. This added to the cluttered appearance of the space and was not in-line with good infection, prevention and control measures.

The lack of effective infection control procedures and failing to provide a safe environment for people to be safe from the risk of infections was a further breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider's infection prevention and control policy was up to date.

Using medicines safely
● Medicines were administered by nursing staff. Staff told us they had recently changed from paper medicine records to an electronic medicine management system. They found it hard due to the lack of training they received to understand how to effectively use the management system.
● Medicine stock we checked corresponded with the electronic records. However, we found the medicine and clinical equipment storage room cluttered and unhygienic.
● Clinical sharps bins were of concern, one was not closed properly as a syringe was blocking the lid, and one appeared to have dark red splatter on the lid. The medicines administration tabard used by nursing staff to alert others not to disturb them when administering medicines was hanging on the bin. This was an infection control risk.

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 last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Adapting service, design, decoration to meet people's needs; Staff working with other agencies to provide consistent, effective, timely care

- People's needs were assessed before they moved in the home. However, care plans developed were not always personalised, relevant or up to date. For example, we found four occasions where the care plans for people we reviewed had other people's names in. This increased the risk of staff providing people with incorrect care and support. For example, one person had a skin integrity care plan in place with another person's name in it and further on within the same section another person's name.
- Care plans and reviews were conflicting on what needs people had and how staff had to support them safely. For example, for one person their care plan said they needed one staff member's assistance to mobilise and in another area of their plan the records suggested they were independently walking.
- Relatives told us they were visiting often to ensure the care and support people received was safe as they felt agency staff used were not always knowledgeable about people's needs. We found examples of relatives raising concerns that people had infections and required a medical professional input. At times, this had not been identified by staff or then actioned and people were then admitted to hospital due to their health declining further.
- In some instances, there was a delay in involving the right health professionals in people's care. For example, weight loss had not always been identified promptly and input from dieticians or the GP had not been requested in a timely way. A visiting health professional told us staff were inconsistent with their reporting on people who were unwell. They told us staff escalated concerns too quickly for some people who only needed re-positioning or correct positioning for their breathing to improve when other people were left to be seen at a weekly routine visit when they should have been escalated sooner. This put people at risk of their health deteriorating further and avoidable hospital admissions.
- The physical environment had not been adapted to take into consideration the needs of people living with dementia. For example, there was a lack of signage to support people who lived with dementia to walk around the home. This meant people could not easily orientate themselves within the home. There were no interactive or dementia-friendly resources used to help people to keep interested or objects of interest for when they were walking with a purpose.
- There was not enough equipment available for staff to support people effectively. People who needed the aid of a hoist and slings to support their mobility shared slings with other people as well as having to wait their turn for the hoist. There were only two full hoists available for more than 20 people.

Failing to meet people's needs and seek professional input to maximise people's health and well-being was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the provider carried out their own assessment for the required equipment to meet people's needs and they ensured this was delivered promptly to the home.

Staff support: induction, training, skills and experience

● Staff told us they were not supported or listened to by the registered manager. One staff member said, "The deputy manager is approachable but not the [registered] manager. I have spoken to [the registered manager] a few times and they had not taken any action. They are dismissive." Every staff member we spoke with gave us the same feedback about the registered manager and praised the deputy manager.

● Staff had not been provided with appropriate professional support. Regular one to one supervision had not been completed. One staff member told us they had a supervision recently but, before this, for a whole year they had not received any one to one support. Staff did not have opportunities to review their work and to discuss their development and support.

● Staff had received training in key areas, such as safeguarding and mental capacity. However, most courses were online, and staff told us they knew that some staff had completed training for others. One staff member said, "(Staff) are lovely but some have a language barrier and they do not understand people. They cannot understand their training." The registered manager did not carry out formal competency checks for staff or observations of the care people received from them. They failed to ensure support was available for staff who may have had difficulties in communicating and understanding English. This meant there was a risk of some staff not understanding how to support people safely and this put people at risk of harm.

● Staff provided care to people living with dementia, people who were at their end of life and people who needed support with their skin integrity and nutrition. Staff had not been provided with training in these critical areas.

● The registered manager failed to ensure that newly employed staff fully completed their induction and achieved the Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.

The provider had not ensured that staff were provided with the necessary training and professional development to support people safely. This was a further breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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

● People and relatives gave mixed feedback about the meals people received. Relatives told us there were times where there was a lack of choice for people who needed specialist diets due to swallowing problems they had.

● People were supported to eat and drink, however not always in a pleasant and comfortable environment. A high number of people were supported by staff to have their meals in their bedroom whilst in bed. We observed some people were not positioned comfortable whilst eating. For example, a person had slipped right down in bed and could not straighten their legs. Another person had been left to eat whilst being on their side. This put people at risk of choking.

● Some people had their food and fluid intake monitored. This was because they either lived with a medical condition and they had to have a controlled intake or because they were identified being at risk of malnutrition or dehydration. We observed on the first day of the inspection that some people had their drinks out of reach and, when staff were busy in providing personal care, there were three to four hours gaps

between people being offered a drink.
● Food and fluid monitoring charts were not completed accurately. This made it difficult for any reviewing health or social care professional to make a judgement on what additional support people may need. In addition, the staff's daily catch up meeting to discuss any concerns about people's food and fluid intake happened late in the afternoon. This meant a missed opportunity to identify earlier in the day if people needed extra support or should to be referred promptly for professional support.
● Following the inspection, the provider changed the time of the meeting to midday and this gave staff more time to take actions 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 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.

● Mental capacity assessment or best interest decisions were not always in place for restrictions applied to people's freedom. For example, for people who were permanently cared for in bed and bed rails were in use, there were no MCA or best interest decision in place to show these were used for safety reasons and not to prevent people from getting out of bed.
● Records relating to MCA were incomplete and lacked detail. Although the registered manager had asked staff to review these, they continued to lack information and detail. Often there was an MCA carried out to assess if people had capacity to make an informed decision about living in Cromwell House Care Home which found that they lacked capacity to take this decision. However, there were then no other MCA's or best interest decision for these people for other decisions such as taking medicines or receiving personal care. This was an area the provider was addressing at the time of the inspection, but remained an area requiring improvement.

Inadequate

Is the service caring?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate.This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care

- People and relatives told us that individual staff members were kind and caring, however the systems and processes in place prevented staff from supporting people in a caring way. For example, night staff provided personal care and dressed some people very early in the morning to ease the pressure on day staff. We observed in the morning of one of our visits people were fully dressed in their clothes but were in bed, covered and asleep. Records confirmed that these people had received care and support as early as 4:00am and were then left to continue to sleep in their clothes. This practise did not promote caring and personalised support for people. The registered management had not identified this, and staff had not considered the risks to people when fully dressed covered in bed, especially in hot weather.
- People had limited input in their care. In some instances, care plans had information about people's likes and dislikes, however there was no time for staff to ensure they supported people as they liked. For example, some people had a well-established routine to get up or go to bed. However, there were not enough staff to take people's wishes into account and people had to wait their turn.
- We observed staff being rushed and not having the time to spend with people, although some people clearly indicated the need for reassurance and support. For example, we observed three people sat by the nurse's station on the ground floor. They were disorientated, anxious, asking what the time was and when was lunch time. Staff members walking through this area answered their questions in passing but had no time to stop. Staff failed to validate people's reality, feelings and failed to demonstrate understanding and warmth towards people.
- We heard a person calling out from their bedroom. Their door was open, and they were in their bed. A staff member went in and asked what they needed. The person started shouting, "I just want some company! I am not comfortable." The staff member could not calm them, and they walked out leaving the person to shout. This meant staff had not enough knowledge about the person to support them in a caring way.

The lack of personalised support and failing to promote and support people's individual needs was a further breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- One person said, "They [staff] are all nice to me here. They are good." A relative said, "I feel sorry for the carers. They are running around and trying their best. The problem here is the leadership, staff are very nice."

Respecting and promoting people's privacy, dignity and independence

● People's dignity was not always promoted. Staff at times used labelling language and failed to protect people's dignity. For example, one staff member told us when we asked about the plated meals left in the dining area, "Those are for staff. All residents [people] are fed before staff!" Another staff member was loudly asking for air freshener after a person used the toilet, not thinking that this would embarrass them.

● The lack of meaningful training for staff and lack of leadership in the home, allowed for the development of a task led, negative culture where people were the object of work and not treated as individuals. For example, we heard staff talking on the corridor when they were supporting people with personal care in the morning saying, "We'll do [name of person] next."

● The majority of people were cared for in bed or in their bedroom. Bedroom doors were left open; therefore, any visitor could see people in bed or in their bedroom throughout the day. Staff or management in the home had not considered the impact of this on some people's dignity whilst they were left in bed only wearing their continence pads or night clothes.

● Relatives told us staff had no time to support people to maintain the independence they still had. For example, one person was still able to stand and transfer with staff's support from their bed. The relative told us, this took time and staff used the hoist as it was quicker. This lack of support with movement could further reduce the persons mobility.

The lack of dignifying care and support people received was a breach of Regulation 10 (Dignity) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed 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

- People received care and support which did not take account of their likes, dislikes and preferences. The care and support centred around staff routine and availability and not around meeting people's needs in a personalised way. For example, people were not getting out of bed when they wished. One relative told us, "[Person] really likes to be out but they [staff] only get them up every three to four days. I don't really know why?"
- Care plans were task led, generic and with little guidance or information for staff to provide person centred care. Even when care plans gave clear instructions for staff to follow, they failed to do so. For example, we found several examples where people who had diabetes needed their blood sugar levels monitored and taken before meals. We found staff had not followed this and often recorded blood sugars taken after people had their meals. This made it difficult for health professionals to accurately assess and prescribe medicines for people to manage this condition.
- People supported in bed were at risk of social isolation. Some people had hardly left their bedroom since they moved in the home. There was no time allocated for staff to engage and spend quality time with people. One relative said, "There is a need for more interaction and activities for people who are in bed, they have very little opportunities, only the visitors."
- People had not been supported to go out and engage in the local community. People who needed the use of a wheelchair had difficulty accessing the garden. Paths were uneven and it was difficult to push wheelchairs through the grounds. There were no trips away from the home and a lack of entertainment or other meaningful occupation opportunities for people to spend their time without boredom.

The lack of reasonable adjustments for people to receive care and support in a person-centred way and a lack of engagement opportunities provided was a further breach of Regulation 9 (Person-centred care) of the 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.

- Care plans were not well developed to detail the preferred methods of communication people had, including the approach to use for different situations. This was an area where further improvements were

needed to ensure staff had available tools such as electronic devices, white boards or picture cards to use to aid communication with people.
● We observed staff communicating with people well and there were also transparent face masks for staff to use when supporting a person who used lip-reading to communicate.

Improving care quality in response to complaints or concerns
● Concerns and complaints raised with the registered manager were not always documented. Complaints recorded were responded to in line with the provider's complaints policy, however learning or actions resulting from these were not shared with staff or implemented effectively.
● Relatives told us the registered manager was not approachable or visible in the home and they were not confident in approaching them to raise concerns. One relative said, "I don't want them to stop me visiting so I don't raise complaints."
● Staff told us they had stopped raising concerns with the registered manager because they were not listened to, and no actions were taken. One staff member said, "The [registered] manager is not approachable, and I won't raise any concerns with them anymore. I talk to the deputy manager. They are very good."

End of life care and support
● People were not involved in planning for the future and what they considered important when they were nearing the end of their life. Care plans around people's end of life care were basic and often limited to record if people had made a decision about whether to be resuscitated or not.
● Staff had no training to understand best practice, current requirements and expectations when supporting people nearing the end of their life.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed 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

- The management team and staff did not demonstrate they understood their responsibility to provide safe care and treatment to people. In January 2022, the nominated individual was made aware by CQC of whistleblowing concerns we received. These were in relation to staffing levels, people not receiving safe pressure care, a lack of personal care and the general conduct and poor attitude of the registered manager. They gave assurances to CQC that these areas were being managed and were not a concern.
- During this inspection we found serious concerns relating to risk management, keeping people safe from harm, staffing levels and management oversight and governance. These were similar themes that were reported to the nominated individual in January 2022.
- The registered manager and nominated individual told us staffing was based on a dependency assessment of people's needs. They told us they used this to calculate the hours of care required across the service. However, they failed to ensure that the data they based their dependency tool was accurate.
- Evidence we found to demonstrate insufficient staffing included people not being repositioned as required, fluids not offered in sufficient quantities, the lack of personalised care and people being supported with personal care in the middle of the night. Therefore, we considered that the dependency tool used by the registered manager and provider was inadequate.
- We found that records about people's needs were not accurate. These included people's individual care plans, daily monitoring records for people such as food and fluid, personal hygiene, wound management and accidents and incident records. For example, we asked for a body map to be completed for each person in the home because we could not be assured that all wounds were accurately recorded. As a result of this, two additional pressure wounds were identified that required additional care.
- The provider failed to ensure immediate actions were taken in response to their own audits carried out at the home where they identified issues with poor care, staffing and lessons not learnt. In July 2022, the provider carried out an audit in the home and found that people were not positioned in bed according to their care plan, experienced poor care and there was a shortage of staff. Their lack of action meant that people experienced poor care for a longer period of time than it was necessary or acceptable.
- There was a quality and assurance process in place, which was not effectively used by the registered manager. For example, they had assessed care plan completion in July 2022 as 100%. Representatives of the local authority commissioning team found, and we found, care plans were incomplete, contained the wrong information and gave confusing and inconsistent guidance to staff. For example, care plans for some people had different people's names in them, risk assessments for identified risk such as diabetes were not always in place and risk assessments in place lacked details of how to manage risk effectively. This put people at

risk of harm.
● There were missed opportunities for lessons learnt and improving people's experience of the care they received. None of the complaints, safeguarding incidents or the provider's own assessments of the service triggered a lessons-learnt process. Trends and patterns of accidents or incidents and complaints were not analysed therefore no attempt was made by the registered manager to understand why these were happening and explore ways these could prevented. For example, there were nine pressure ulcers people had developed in the home. The registered manager had failed to identify that people were not repositioned at the required intervals, mattresses were not set correctly and the lack of staff being a contributing factor to people receiving unsafe care.

The provider's quality assurance systems and processes were not effectively used to assess, monitor and improve the quality and safety of the service. This was a breach of regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Relatives, staff and visiting professionals told us there was a blame culture in the home. They told us staff were being blamed for all the shortfalls identified and often observed the registered manager "telling staff off" in corridors.
● Everyone we spoke with were positive about the deputy manager. They told us they were hard working, diligent and exceptionally caring. We observed throughout our inspection the deputy manager working hard to support people and staff, but they were overwhelmed and working under stressful conditions with little support from the registered manager.
● Staff morale in the home was low. Staff told us they did not feel supported or valued. Staff told us when they raised a concern they were shouted at by the registered manager, so chose to not raise any concerns with them. A staff member commented, "The [registered] manager is not supportive or approachable. They blame us (staff) for everything."
● Relatives told us they felt the staff team were under pressure to complete tasks and were worried about staffing levels and the impact this had on the team. One relative said, "I do feel sorry for the staff. They have no leadership, not enough staff and no support. It's a worry because they may leave and then it's even more agency used."
● Relatives and staff told us the registered manager did not promote a value-based work ethic and did not demonstrate the qualities of a good leader. Staff told us the registered manager frequently left the home throughout their working hours and were not available to offer staff support. Concerns about the conduct of the registered manager were raised in January 2022 to CQC and we shared these concerns with the provider. The nominated individual provided CQC with assurances at that time that there were no concerns with the registered manager's conduct. However, we found this practise ongoing at this inspection.
● Staff and relatives told us poor communication was a theme throughout the home which did not promote good outcomes for people. Staff meetings were not a regular occurrence and were used to inform staff what was expected from them and not as an opportunity for meaningful engagement and partnership working. Relatives told us the registered manager was not visible in the home. They told us recently they observed a notice advertising for open surgeries with the registered manager, however they were unsure if this was available for visitors or just staff. They told us they were not always kept up to date when people's health needs changed.
● People, relatives or staff were not involved in the running of the home. Their opinions and feedback about the service they received was not always sought or listened to.

Failing to ensure appropriate leadership and positive inclusive work ethic led to a poor culture developing in the home and had a negative impact on people. This was a further breach of regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 told us they understood their legal responsibilities in relation to the duty of candour, however, they had failed to ensure they were aware of all accidents, incidents and near misses at the service so they could ensure they were consistently meeting this. For example, injuries were reported to the manager, but this did not prompt them to follow the duty of candour principles.

Working in partnership with others

● Staff worked with other healthcare professionals although referrals to their services were at times delayed. Records showed involvement from dieticians, speech and language therapists and diabetic specialists.

● The management team did not always seek support with external stakeholders to address issues. For example, the registered manager told us they were experiencing difficulties with the GP surgery. They had attempted to resolve these issues, but when things did not improve, they did not seek support and intervention from the local health authority.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Person-centred care Regulation 9 (1) (a) (b) (c) (3) (c) (h) Care was not provided in a manner that met people's needs and preferences or was appropriate. Care was not provided in a way that enabled and supported relevant persons to understand the care or treatment choices available to them and to discuss, with a competent health care professional or other competent person, the balance of risks and benefits involved in any particular course of treatment. Reasonable adjustments to enable the service user to receive their care or treatment were not made.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Dignity and respect Regulation 10 (1) (2) (a) (b) Service users were not treated with dignity and respect that supported their privacy or their autonomy, independence and involvement in the community.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding service users from abuse and improper treatment Regulation 13 (1) (2) (3) The provider and the registered manager failed to operate effective safeguarding processes and learn lessons when things went wrong. This led to people experiencing abuse. Systems and processes were established, but not operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse.

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 Staffing Regulation 18 (1) (2) (a) Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed. This led to people experiencing harm. Staff employed did not receive appropriate support, training, professional development or supervision as is necessary to enable them to carry out the duties they are employed to perform,

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Safe care and treatment Regulation 12 (1) (2) (a) (b) (h) Care and treatment was not provided in a safe way. People's needs were not always assessed and risks to people safety and welfare were not managed to keep them safe from harm . Risk relating to the prevention, detection and control of the spread of, infections, including those that are health care associated were not safely managed.

The enforcement action we took:

We cancelled the managers registration

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 Good governance Regulation 17 (1) (2) (a) (b) (c) (e) (f) Systems or processes were established but not operated effectively. The registered manager failed to assess, monitor and improve the quality and safety of the services and implement measures to mitigate those risks and improve the quality of care. Accurate, complete and contemporaneous records in respect of each service user were not maintained. Feedback from relevant persons and other persons on the quality of care was not effectively sought. The registered manager did not evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to

(e).

The enforcement action we took:

we cancelled the registered manager's registration