The Fremantle Trust

Sir Aubrey Ward House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Sir Aubrey Ward House is a residential care home providing accommodation and personal care for up to 60 people aged 65 and over. Thirty eight people were living there at the time of the inspection.

People can be accommodated in one of four separate wings, each of which has separate adapted facilities. One of the wings specialises in providing care to people living with dementia. One wing was not in use at the time of this inspection.

People's experience of using this service and what we found
There had been several changes to staff since the previous inspection, including managers. We saw appropriate checks had been carried out for temporary and permanent staff before they started working at the home. We received mixed feedback from people we spoke with or who contacted us. Some spoke positively about the support they or their family members received, whilst some relatives told us the changes to staffing meant there was often a lack of continuity in their family members' care.

Some staff had worked excessive hours at the home recently to cover other staff vacancies and unplanned absences. We received concerns about staff cover at night time. A community healthcare professional told us about five occasions when they had visited and they felt there had not been enough staff to support people. On the second day of the inspection, the manager took steps to increase staffing levels in one part of the home where people had higher care needs, to address this.

We found staff, including senior staff, did not have knowledge of people's past histories because they had not worked at the service long enough. Community healthcare professionals expressed concern about this as staff were unable to advise them about people's medical histories. We observed staff to be focused on tasks rather than responding to the needs of people. For example, we heard staff comment to each other about how cold it was in a lounge where people were sitting. No one attempted to provide people with blankets, warmer clothes or adjust the heating. Staff did not always promote people's dignity in the way they supported them. We observed people who were exhibiting signs of distress were either ignored or given basic and non-meaningful responses by staff.

People were not supported to be protected from abuse. The provider and staff failed to recognise when people were subjected to avoidable harm, events which had caused injury or harm to people had not been reported to the local authority safeguarding team for them to investigate. This meant there was a danger the event could reoccur.

The provider had systems to support staff through supervision, appraisal and training. However, we found people were cared for by staff who had not received regular supervision or an appraisal, to help them develop professionally. Training was being brought up to date by the provider to ensure staff had the skills they needed to meet people's needs.

People were not fully protected from the risk of fire. Checks and servicing took place of fire safety equipment. However, we found not all staff, particularly night staff, had been instructed on what to do in the event of a fire. This meant they may not know how to safely evacuate the building. The provider had started to take steps to address this whilst the inspection was on-going.

People were not protected from the risk of infection. Staff did not follow good practice to prevent cross-infection. For example, there was no separation of clean and contaminated items in sluice rooms. Laundry and sluice areas were cluttered, making them difficult to keep hygienic. There was a risk infections could spread from person to person in these conditions. The provider was unable to demonstrate any infection control audits had been carried out at the home, to show they had been monitoring practice during the coronavirus pandemic.

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

People did not routinely have their nutritional and hydration needs met. We found people were at risk of weight loss and some people had experienced actual weight loss.

We were unable to see that complaints were managed effectively. Records we were provided with were not sufficient to show complaints were always investigated and a response sent to the complainant.

People told us communication with the home was poor. Feedback from people and their relatives included "I think I'm losing my marbles because all these things are happening and [the management] just brush over it" and "We don't know where the managers have disappeared to…you get to know them and then [they're gone]." The provider failed to report to us all events they were legally required to. The provider failed to ensure they had effective systems in place to comply with the regulations. Audits carried out by senior were ineffective and did not drive improvement. Records management at the home was poor, it was disorganised, inaccurate and contradictory. The provider had failed to act on our previous feedback about the quality of the care provided. We found people were experiencing poor quality care which had the potential to put them at risk of harm.

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

Rating at last inspection and update
The last rating for this service was Requires Improvement and there were breaches of regulations regarding safe care and treatment and governance of the service (report published 25 January 2021). The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection enough improvement had not been made and the provider was still in breach of regulations. The provider has not achieved a good rating in the safe domain for the last five consecutive inspections.

Why we inspected
We received concerns in relation to management of the home, the high number of unwitnessed falls, unreported safeguarding concerns and the management of people's health and staff support. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

The overall rating for the service has changed from Requires Improvement to Inadequate. This is based on

the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe, effective and well-led sections of this full report.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to how people are supported to receive dignified care and how they are supported in line with the Mental Capacity Act (2005). We also have concerns about the management of risk and how people are supported to meet their nutritional needs. Other areas of concern are staffing levels and how staff are deployed, supervised and trained, safeguarding people from abuse, and the provider's oversight of the service to ensure the service is well run and regulations are met.

Please see the action we have told the provider to take at the end of this report.

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 following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 six months to check for significant improvements.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Sir Aubrey Ward 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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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

Inspection team
The first day of the inspection was conducted by two inspectors, a medicines inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The second day of the inspection was carried out by two inspectors.

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

Whilst the inspection team were on-site, the home did not have a manager registered with the Care Quality Commission. A registered manager had transferred from another of the provider's care homes and had been at Sir Aubrey Ward House for one week when the inspection started. During the course of the inspection the manager applied to transfer their registration and they are now the registered manager of Sir Aubrey Ward House.

Notice of inspection
This inspection was unannounced. Inspection activity started on 27 October 2021 and ended on 12 November 2021. We visited the care home on 27 October and 3 November 2021

What we did before inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We 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 all of this information to plan our inspection.

During the inspection
We spoke with nine people who lived at the home and one relative. We spoke with 14 staff in a range of roles, including the registered manager, operations manager, quality lead, care staff, auxiliary staff and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We contacted 44 staff and 28 relatives by email, to invite them to provide feedback.

We looked at some of the home's records. This included 11 people's care plans, three staff recruitment files and training records for all staff. We checked a sample of internal audits and monitoring reports and records of complaints. Other records included maintenance and upkeep of the premises, health and safety records and a sample of policies and procedures.

We observed mealtimes in different parts of the home and a handover meeting between the manager and staff. We checked medicines practice including observation of a medicines round, completion of administration records and storage of medicines.

After the inspection
We continued to seek clarification from the provider to validate evidence found and to request further information. We reviewed further information requested from the service. We made a number of requests for additional information. However, the provider either failed to ensure we received this or we received information after a long time. We had concerns about people's safety and well-being. We made referrals to health colleagues and made four safeguarding referrals to the local authority.

Inadequate

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly assess the risks relating to the health, safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection people continued to be put at risk. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● People were not routinely and effectively protected from potential avoidable harm. We found the provider had not ensured they had done all that was reasonably practicable to mitigate risks. Risk assessments had not always been completed when required or lacked accurate detail to mitigate harm to people.
● People's risk of malnutrition had not been assessed accurately which placed them at risk of not receiving sufficient nutritional support to maintain a healthy weight. We found records showed excessive weight loss in short timeframes. For instance, one person's records showed they had lost 23 kg, another person had lost 6.4 kg from March 2021 to May 2021, a third person had lost 9.4 kg from July 2021 to October 2021. The service used a nationally recognised assessment tool called 'Malnutrition Universal Screening Tool' (MUST). We found this assessment was routinely completed incorrectly. We were so concerned about the risk of weight loss we made urgent referral to health colleagues and asked the service to review every person's weight and take action.
● The home's training records up to 3 November this year showed only 58% of staff had attended a fire drill. Records of fire drills showed there had only been two fire practices for night staff. One was held in June this year but the record of it did not contain information about how long it took or areas for improvement. A second simulated drill was carried out in October this year, which six night staff attended. We could not be confident that all staff had received training or would know what to do in the event of a fire.

We found the service had not addressed our previous concerns about the management of risk and systems were not in place to ensure people were protected from potential risks. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the provider had not done all that was reasonably practicable to mitigate the risks to the health and safety of people.

● Fire prevention measures were in place. Regular testing was carried out to ensure fire call points worked and the means of escape around the building were clear. Personal emergency plans were in place to outline

the support people would need if the home needed to be evacuated.
● Following the inspection, the manager told us further fire drills had been carried and 71% of staff had now received training on fire drills, as of 10 November 2021.
● Equipment was serviced to make sure it was in safe working order. For example, electrical appliance testing took place.
● The premises had been well-maintained. We saw checks had been made to ensure water, gas and electricity supplies were safe.

Using medicines safely
● People were not routinely and safely supported with their medicines.
● People who were prescribed medicines such as pain killers, laxatives and anxiolytics to be taken on a when required (PRN) basis were not routinely supported safely. Guidance in the form of PRN protocols or information in care plans was not always in place to help staff give these medicines consistently.
● We observed staff administered medicines to people in the morning and afternoon. Staff did not routinely follow good practice while giving medicines. One member of staff signed for medicines as being administered on the Medicine Administration Records (MARs) before administering them. This was contrary to National Institute for Health and Care Excellence (NICE) guidelines.
● Improvements were required in the safe storage of medicines. There was a risk medicines were not always stored at appropriate temperatures. The records for temperature monitoring for medicine storage rooms was 25 degrees Centigrade on most days. It is unlikely for there to be the same temperature throughout the month in different rooms of the building therefore we could not be confident these readings were accurate.
● We found the controlled drug cabinet had the potential to be accessed by unauthorised personnel as the key was not stored securely.
● Care plans were not always person-centred. Information was not routinely and consistently in place to help staff monitor or manage side-effects of anticoagulants. Information for time-specific medicines was not included in their care plans. This meant there was a potential for staff to provide inappropriate or late support in managing people's health conditions like Parkinson's Disease, for example.
● There was no process in place to receive and act on medicines alerts from the government Medicines and Healthcare products Regulatory Agency.

The provider failed to ensure the proper and safe management of people medicines. This was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us they received their medicine by staff who they thought conducted it well.
● There was adequate stock of prescribed medicines. There was a process in place to record and return waste medicines to the supplying pharmacy for disposal.

Preventing and controlling infection
● Senior staff could only tell us about infection control practice over the past month, when they had joined the service. We were unable to determine how the home had responded to the coronavirus pandemic prior to this, as there was no one at Sir Aubrey Ward House who had this knowledge.
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. We found there was no clear separation of clean and contaminated items in areas of high risk, such as sluice rooms. For example, clean clothes were hanging on airers next to machines used to disinfect equipment. In the laundry, items for handwashing and sanitiser were stored on top of the grille over the sluice. There was no plan in place to prevent one person who was at high risk of spreading infection to others from doing so.

● Sluice rooms were cluttered and untidy, making them difficult to keep clean and prevent cross-infection. Staff told us plastic jugs we saw stored in a shared bathroom were for emptying catheter bags into. There was no single-use equipment or disinfection guidelines to ensure hygienic disposal of urine.
● We were not assured that the provider was making sure infection outbreaks could be effectively prevented or managed. The laundry was cluttered with four trollies from a local supermarket. Laundry bags containing contaminated items had fallen out of the overfilled skip and on to the floor. On the first day of our inspection, there was no hand sanitiser for people to use before or after they entered some parts of the home. This was rectified by the second day of the inspection. The provider was unable to supply us with evidence of any audits carried out to assess the home's compliance with infection prevention and control measures.
● We were assured that the provider's infection prevention and control policy was up to date. However, our findings showed staff were not consistently following this.
● We were not assured the provider was doing all that was practicable in preventing visitors from catching and spreading infections. We found visitors at weekends did not always have to demonstrate compliance with current best practice on COVID-19 testing.

This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the provider had failed to ensure they had appropriate measures in place to assess and control the spread of infection.

● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Systems and processes to safeguard people from the risk of abuse
● People were not routinely and consistently protected from potential abuse. We found staff failed to recognise situations which needed to be reported to the local authority as a safeguarding concern. In July this year the local authority found many incidents which should have been reported to them. They asked the provider to make retrospective safeguarding alerts to them. The local authority confirmed they have received 89 safeguarding referrals from various sources since March 2021 to date.
● We found people were placed at potential risk of harm as uninvited people often entered their room. On day one of the inspection one person entered another person's room and promptly sat on their bed. The person whose bedroom it was, told us "It's something that happens in this ward". Staff were unaware this had occurred, until they were informed by us.
● The provider failed to ensure robust procedures were in place to ensure when safeguarding concerns were raised, they were dealt with swiftly. People were put in danger of improper treatment and support.

The provider failed to ensure systems and processes were in place and followed to prevent abuse. This placed people at risk of harm. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Deployment of staff was insufficient and there were not enough staff to meet people's needs.
● Due to several staffing changes over recent months, managers, senior staff and care workers did not know about people's histories and could only tell us about events which had happened whilst they had been at

the home. In some cases, this was one month.
● A community healthcare professional told us about when they visited on one recent occasion. They said, "Staff had no knowledge of the patient's past medical history and were unable to give clear feedback to when the symptoms started, when the GP was informed and was unaware when the district nurse was due to attend." They commented about two other occasions where "Staff knew little about the patient" and where another person had lived at the home for three months "And (staff) had no knowledge or documentation regarding past medical history." Another community healthcare professional told us this had also been their experience.
● Feedback from some other people was critical of how the home was staffed. This included staff working excessive hours to cover the home. We were able to see this from looking at staff rotas where, for example, a member of staff had worked six consecutive long days during October this year. Staff also told us there were not enough care workers at night time and being expected to leave one unit where they were the sole member of staff, to support another unit.
● A community healthcare professional told us about five occasions this year where they felt there were not enough staff to support people. Examples given included "One care worker to 16 people," "Home under-staffed and patient not being monitored," and "Two carers on the shift with 30 residents, with 15 reported needing high support."
● The nominated individual told us they based staffing levels on one member of staff to six people. We queried this as we did not believe people would be safe with this number. On the second day of the inspection, the registered manager took steps to increase staffing levels in one part of the home where people had higher care needs.
● Relatives told us the frequent changes in staffing meant their family members did not have continuity of care.
● We observed staff to be focused on tasks they needed to complete rather than the needs of people at the service. For example, completing records and putting laundry away. We were sitting in a lounge where we heard staff comment to each other about how cold it was in the room. No one attempted to provide people with blankets, warmer clothes or adjust the heating.

This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the provider had not ensured people were cared for by sufficient numbers of suitably qualified, competent and skilled staff to meet their needs.

● Recruitment records showed appropriate checks were undertaken before staff started working at the service. This included temporary care workers.
● Handover meetings took place from shift to shift, to update staff on people's well-being and to advise them of any concerns or areas to observe.
● Some people spoke positively of the support they or their family members received. For example, "The carers...are friendly and polite", "I feel all the staff at Sir Aubrey Ward House do a fantastic job, I am very reassured on how my (family member) is being cared for and have been since day one", "They're all good girls (the care staff). We have a bit of a giggle", and "The girls are really good, they really care."

Learning lessons when things go wrong
● People were not routinely protected from avoidable harm, opportunities to learn lessons when things went wrong were not always carried out. Accidents and incidents were recorded. However, there was a lack of managerial and provider oversight of these, to take action to prevent a re-occurrence.
● The provider failed to act on feedback provided to them. This was demonstrated by continued breaches of regulations at this inspection. The provider was informed by the local authority in July 2021 about serious failings in the service. However, our findings from this inspection show little improvement had been made.

We found the provider had not addressed our previous concerns about the management of risk and systems were not in place to ensure people were protected from potential risks. The provider continued to put people at risk of harm. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Since the registered manager has been in post they have implemented systems to ensure opportunities for lessons to be learnt are carried out.

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 the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

At our last comprehensive inspection in March 2019, the provider had failed to ensure people were cared for by staff who received sufficient supervision and appraisal to enable them to carry out their duties. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

- Staff had not consistently received support and training to meet the needs of the people they cared for.
- The registered manager told us only two care staff had completed the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers need to demonstrate in their work. They include privacy and dignity, equality and diversity, duty of care and working in a person-centred way. Our observations during the two days of inspection showed staff did not always demonstrate these fundamental standards when they supported people. The registered manager told us 42 staff had been allocated to complete the Care Certificate.
- Supervision had not taken place regularly for all staff, from the records we looked at. One member of staff had met with their line manager four times this year in our sample of eight files. Another member of staff had only been supervised once. Seven of the files contained what was termed 'group 1:1.' Records for this showed the same typed phrasing in each file and focused on collective responsibilities (record keeping, Covid testing, uniform policy), with no individual discussion about performance or any issues staff may have encountered. In one file for a newer member of staff, this was the only record of supervision. This was insufficient to demonstrate staff were being appropriately supported and developed in their roles.
- Our sample of files showed one member of staff had an appraisal within the past year and another last received an appraisal in 2018. The registered manager told us only 20 out of 89 staff had been appraised in the last year.
- The provider had a system for evaluating performance of new staff using probationary assessments, at two set intervals. We were unable to see from personnel records that these assessments had always been completed, to ensure staff worked to expected standards.

This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the provider had not ensured staff had received appropriate supervision,

professional development and appraisal to enable them to carry out the duties they were employed to perform.

● The staff team was collectively at 80% compliance with training the provider expected them to complete. The aim was to reach 90%. We could see courses had been booked and some had been undertaken between the inspection dates, to improve training targets. The registered manager had written to staff to chase completion of on-line courses.

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

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

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

At our last comprehensive inspection in March 2019, the provider had failed to act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice. This was a breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 11

● People were not routinely and consistently supported in line with the code of practice of the MCA. We found mixed practises and inconsistent record-keeping.
● We found mental capacity assessments which had been completed detailed the decision which was being made. These ranged from people accepting care to people residing behind a locked door or receiving a vaccination. The decisions and records surrounding decisions were basic and did not routinely provide a full record of discussions held.
● We found records showed where the person lacked capacity to make the decision a best interest process was not routinely followed appropriately. We found records did not always show the full discussion or any discussion held with third parties. This is important to ensure decisions were made in people's best interests.
● One person had a mental capacity assessment completed which concluded they had capacity to consent to a specific restriction of their movement, however the provider then completed a best interest process, which was not required if the outcome was accurate. A best interest process should only be following if the person has been assessed as lacking in capacity for a specific decision.

The provider failed to ensure they supported people to make decisions in line with the code of practice of the Mental Capacity Act. This was a continued breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People were not supported to ensure they had all their needs met on a daily basis. We found people were not supported in line with their chosen preferences. For instance, one person's care plan detailed they wished to have a daily shower, however records viewed did not demonstrate this had occurred.
● We found people were looking dishevelled and unkempt. We checked personal care daily records and found staff had recorded people had refused. Relatives and friends of people told us they were concerned about people's personal hygiene. Comments included "We are unsure how often [name of person] has a shower, he requires assistance to have a shower and his memory is not what it was. He often thinks he has had a shower when he has not", "I mentioned on several occasions that regular showering was not taking place. A carer was eventually (after 5 months) assigned to help three times a week".
● Other relatives told us they also had concerns, comments included, "We have always been concerned about the continuity of [relative's] personal care on the occasions when her key worker has either been on holiday or off sick. At such times no alternative arrangements were in place for another member of staff to be assigned to her personal care such as baths, hair wash and assistance with changing her bed. This at times has resulted in her going 10-14 days without a bath", "Sometimes he is just wearing just a t shirt, no jumper. Sometimes no socks" and "She has started to look a bit dishevelled, with very dirty fingernails and slippers on the wrong feet and her hair not brushed."
● People who were living with dementia or varying levels of confusion were not supported in line with best practice and guidance. One person's care plan stated they became distressed in loud and busy environments. However, on day one of the inspection we observed the person attempting to eat a lunchtime meal in a dining room, at the same time staff were banging crockery, loading a dishwasher, a radio was playing pop music just outside the dining area and a television on in the adjoining room which could be heard. Towards the end of the mealtime a member of staff vacuumed close to the dining room using a loud industrial machine. Inspectors were unable to communicate to each other due to the noise. The person was distressed. We advised staff of our observations to prevent the on-going situation.
● People who experienced periods of distress and either verbalised this in spoken language or by hitting and grabbing at staff were not supported by staff who understood their needs. One person's care plan stated "I do get stressed from time to time and very angry", the advice for staff was "Staff to leave [name of person] to calm down ensuring she is safe, medication is available if needed." No information or advice was available to staff on what the triggers were for the level of distress. Another person who demonstrated varying levels of distress had a care plan which stated what triggered their level of distress, the plan stated the person responded to holding and touch and reassurance from staff they were safe. However, we observed staff walking away from the person when they were showing they were distressed.
● We observed another person walking around the home saying, "Help me, please help me," no staff offered the person reassurance or acknowledge what they were saying. We observed staff failed to ensure people's dignity when they used communal toilets. We observed the door left open when someone was using the facility.

We found people were risk of not receiving a dignified service which supported them to experience health and wellbeing. This was a breach of regulation 10 (Dignity and respect) 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 nutritional needs were not always effectively met. People did not consistently receive the support

they needed at mealtimes. We observed people at two lunchtime meals. One person was seated in the corridor and their meal was located on a small table to the side of them. We observed the person pushing the food around on their plate with a fork. At no time did a staff member offer to support them with their meal. Staff took the plate of food away after a short while. We noted only a fraction of the food had been eaten.

● Relatives told us they were concerned about family members' weight loss. One relative told us "The assistant manager told me last week that they are now getting the carers to sit with residents at meals to encourage and assist them to eat. I would have thought this was happening anyway."

● People were placed at risk of dehydration and malnutrition as staff did not routinely ensure records of what had been consumed were accurate. One person's records showed they had consumed two drinks, however, we observed they had been untouched for hours. We found some fluid records indicated people were not always supported to reach their daily fluid intake target. One person's records indicated they had a daily fluid target of 1715 ml, however, records completed showed they had taken less than 1000 ml on 11, 12, 17 and 18 October 2021. We bought this to the attention of the registered manager who agreed to speak with staff and increase staffing levels.

● Staff not considering how to encourage people's appetites. We observed people had attended an activity a short while before lunchtime, people were given chocolate as prizes. Some people who had eaten the chocolate did not then go on to eat their lunchtime meal.

We found people were at risk of malnutrition and dehydration. This was a breach of regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us they were content with the quality of food provided. Comments from people included, "They make good food; it suits me well", "Yes, it's pretty good", "Yes the food's nice… It says on the menu if you don't like it ask for something else" and "Very good. There's plenty to eat".

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

● People were not routinely supported to maintain their health and well-being. This was due to action not routinely being taken in a timely way.

● We found referrals to external healthcare professionals to promote people's health were not always made. We found people had lost a large percentage of weight, when we checked if referrals had been made to health colleagues, we found only two referrals had been made to the community dietitian service. One person's records showed they had lost 7 kg from September 2021 to October 2021, another person's records showed they had lost 6.6 kg in the same period, no referrals had been made or advice sought for the weight loss. We were very concerned about people's health and weight loss. We asked the registered manager to ensure everyone was weighed and referred to the dietitian where appropriate. We also made a referral to health colleagues who arranged a full review of people's needs.

● Community healthcare professionals told us they were concerned about the lack of action taken by the service. One healthcare professional told us the service "Frequently don't use pressure relieving equipment that we provide for their residents…or they will use it on other people living in the home." They also told us they had concerns about people's weight loss.

● On day two of the inspection, an inspector walked into a wing of the home to hear a loud bleeping noise. On investigation it was a warning the pump had failed on a pressure relieving mattress. No staff had responded to this. The inspector sought staff immediate attention to rectify the situation.

We found people were placed at risk of harm of ill health, the provider had failed to do all that was

reasonably practicable to mitigate risk. This was continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The home was a purpose-built property with aids and adaptations to meet the needs of people who lived there. This included adapted baths and showers, grab rails and a passenger lift between floors.
- Each person had their own en-suite room and could personalise these to make them homely.
- Each of the four units had its own lounge, kitchen and dining area, with shared bathrooms and toilets close by. There were quiet areas for people to use.
- There was a communal lounge near the entrance to the home which people could use for activities or other events. A kitchenette led off it, where people could make drinks.
- There was access to the garden from downstairs units and the communal lounge; upstairs units had balconies which overlooked the garden.

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 the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

At our last inspection the provider failed to ensure there were effective systems to monitor and improve the quality of the service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had not been made at this inspection and the provider was still in breach of regulation 17. We found the provider failed to assess, monitor and mitigate risks posed to people. We also found the provider did not maintain accurate and complete records of decisions made about people's care.

● People were supported by a care home which was not well-led, both at provider level and location level. The home had been without a registered manager since February 2020. Whilst we were inspecting the service, a registered manager from another care home run by the same provider had moved across to manage the home. They have now been registered to manage Sir Aubrey Ward House. Relatives told us the lack of consistent management had been concerning to them. Comments included, "The people they've appointed into these [management] positions are lazy and inept… I am upset with the people (management) here… nobody wants to complain for fear of what might happen" and "There have been a significant number of interim managers since mum has been at Sir Aubrey Ward House. Many we did not meet or speak to. This has been concerning." Relatives told us they had reached out to the board of trustees to seek a resolve to their concerns. However, they told us they did not receive a reply from them.
● People were not routinely and consistently protected from risks and avoidable harm. We found the provider did not update people's care plans in a timely manner, following changes to their circumstances. This was because the provider did not have effective systems in place to monitor whether people's care plans were updated when changes occurred in their care needs. This was needed to ensure prompt action could be taken so staff had up to date information about how best to support them.
● We found people's records were either incomplete, inaccurate or contradictory. There was no order to people's records. We found loose papers on desks. We found confidential information was left unattended in a lounge area. There was a lack of contemporaneous records in relation to decisions about people's support. Poor record keeping increased the risk of people not receiving safe care.
● We found the provider had not ensured staff understood the need to meet the duty of candour regulations. The regulation sets out some specific requirements that providers must follow when things go

wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. The regulation applies to registered persons when they are carrying on a regulated activity. We found this did not routinely happen.

We found people were placed at continued risk of harm. The provider failed to act on feedback to ensure effective governance arrangements were in place. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service has been in breach of this regulation since the March 2019 inspection.

● Providers and registered managers are required to notify us of certain incidents or events which have occurred during, or as a result of, the provision of care and support to people. One notifiable event is when there has been an allegation of abuse. We found the provider had failed to ensure we were notified of all the reportable events. This had been identified by the local authority throughout their contract monitoring of the home in July 2021. The provider confirmed they had made 24 retrospective statutory notifications to us for events dating back as far as March 2021.

This was a breach of regulation 18 (Notification of Other Incidents) of the Care Quality Commission (Registration) Regulations 2009.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care; Working in partnership with others
● People were not supported to experience a good quality of life. We found people were left alone in lounges with little interaction with staff. Where staff were present, they appeared to be more interested in completing paperwork than speaking and engaging with people.
● People, relatives and staff provided negative feedback about the management at home level and provider level. Prior to now registered manager being in post there had been many changes in personnel at home management level. We found feedback supported what we found. People told us they did not feel listened to. Comments included "We don't know where the managers have disappeared to… You get to know them and then [they're gone]", "They disappeared… They left. No comment… We've had very many ones in charge" and "I think I am losing my marbles because all these things are happening and [the management] just brush over it".
● The provider's internal auditing systems and processes failed to drive improvement. We found there was a lack of action from the provider when feedback was provided to them. The provider had failed to act on our previous concerns, and we found the service provided to people had deteriorated to a level that had the potential to put people at risk of harm.

Working in partnership with others
● The provider worked with external social and healthcare professionals, this included working with local GP and district nursing services. The provider had been engaging with the local authority, since they identified their concerns in July 2021, regular meetings were taking place with the local authority to assess risk, address concerns and monitor several of the provider's services.
● We found improvements were required in how the provider responded to concerns from partner organisations. There were systemic failings which the provider had not identified as part of their oversight of the service.

We found people were placed at continued risk of harm as effective governance arrangements were not in place. This was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● People's complaints were not always managed effectively. There were procedures for making complaints about standards of care. Records provided to us did not always show how complaints were managed from start to finish. We could not ascertain how or if complaints had been investigated or if they were resolved. We were not provided with evidence that people had always been contacted with the outcome of their complaint.

This was a breach of Regulation 16 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the provider was unable to demonstrate they had an effective system in place to record, handle and respond to complaints.

● Relatives told us communication with the home was poor. Comments included "In the past lack of communication has been an issue; a promised phone call back or email have not materialised We are hoping that with a new manager in place this will improve", "The manager at Sir Aubrey Ward during the worst of the lockdown last year was dire. I received no voluntary communication from the home and had to keep 'phoning for information. When I requested certain information, no one ever called me back and I had to keep chasing for it", and "I would rate general communications with relatives as poor, although people are helpful when you ring up and speak to individuals."

● Some relatives told us use of social media by the home had been helpful for them to keep in touch with what was going on at the home.

● Residents' meetings were held. We could not be certain how useful these meetings were due to some statements being copied into the minutes from one meeting to the next about staffing, safeguarding and medicines. For example, "The residents have all said that they are happy with the staff. Staff are polite and approachable; they are very happy with personal care. Staff show dignity and respect regarding baths and showers" was written following four recent meetings. There appeared to be no follow up to some points raised by people. For example, blood pressure monitoring was requested in May this year and also in October. People said in a recent meeting they would like new managers to introduce themselves.

● The staff team had not been supported through regular supervision and appraisals. Frequent changes to management had caused disruption and not provided opportunity for the home to grow. The registered manager was putting in systems to address this.