Pinford End Limited

Pinford End House Nursing Home

Inspection report

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14 September 2023
19 September 2023
20 September 2023
27 September 2023
28 September 2023

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Pinford End is a residential care home providing accommodation, personal and nursing care for up to 40 people across two floors. The service specialises in nursing care and support for people at the end of life. At the time of our inspection on day 1 there were 35 people using the service.

People's experience of using this service and what we found
The provider's governance systems and audit processes continued not to be robust enough to ensure shortfalls were identified and addressed. Actions the provider told us they would take following our last inspection had not been fully implemented.

The provider had failed to take action in response to fire safety concerns highlighted following external fire inspection visits. Fire safety procedures were unclear, and staff including agency nurses with overall responsibility for the safety of the building did not have access to the training and information they needed to respond in an emergency. This placed people at risk of harm.

The provider did not always respond to safeguarding concerns in line with their own policy and local protocols. Safeguarding processes were not fully effective, and concerns were not always the subject of sufficient scrutiny. This meant people were not protected from the risk of abuse.

Risks to people's health, safety and welfare were not managed effectively, placing them at significant risk. People's care records were not always person centred and accurate. They lacked information to guide staff in how to meet people's needs safely and effectively. When events or incidents had occurred, records did not evidence what action had been taken. There was no evidence lessons were learnt when things went wrong.

Infection control procedures were not always followed to ensure the spread of infection was reduced. Peoples' medicines were not managed safely. Checks for medical devices continued not to be carried out as required.

There were insufficient trained or supervised staff to safely meet the needs of people. People told us there was not always enough staff to meet their needs. Feedback from people using the service and their relatives was inconsistent and while we received some positive comments about the levels of support and quality of care, we also heard concerns about areas such as inadequate staffing, declining quality of food and the providers inadequate response to complaints.

People were not always 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.

We recommended the provider place appropriate accessible signage within the service to enable people

living with dementia to orientate around the building. We also recommended the provider seeks guidance from an appropriate source to increase the use of accessible information to meet people's needs.

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 (published 14 February 2023).

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received by the CQC about safe care and treatment, safeguarding, infection prevention and control, safe medicines management and good governance. We found evidence during this inspection that people were at risk of harm from these concerns.

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.

Enforcement and Recommendations
We have identified breaches in relation to safeguarding people from abuse, safe care and treatment, medicines management, safeguarding, staffing, person-centred care and governance at this inspection.

We wrote to the provider during our inspection due to our serious concerns of people receiving poor quality care. We requested an urgent action plan. The provider told us they had not been aware of the significant failings at the service and risks posed to people's safety and well-being.

The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection.

You can see what action we have asked the provider to take at the end of this full 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 work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect. We will also request an action plan from the provider to understand what they will do to improve the standards of quality and safety.

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.

You can read the report from our last inspections, by selecting the 'all reports' link for Pinford End on our website at www.cqc.org.uk.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

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.

Pinford End House Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the 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 5 Inspectors, including a pharmacy Inspector.

Service and service type
Pinford End 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. Pinford End is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

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

Notice of inspection
This inspection was unannounced.

Inspection activity took place between 14 September 2023 and 28 September 2023.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. This included feedback from stakeholders and professionals who work with the service.

The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

We used all this information to plan our inspection.

During the inspection
We used observation to gather evidence of people's experiences of the service. We spoke with 11 people who used the service and 6 relatives. We spoke with 16 members of staff including the registered manager, deputy manager, administrator, nurses, activities, care staff, cooks and the nominated individual and a company director. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a variety of records including 16 people's care records, staff recruitment, incident reports, audits, medicines records, policies and procedures.

Inadequate

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last inspection the provider had failed to ensure risks had been fully identified, managed and mitigated. 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 we found improvements had not been made and the provider remained in breach of Regulation 12.

- Risks to people's safety associated with improper operation of the premises had not always been identified and action taken to reduce these risks.
- External fire safety specialists audits carried out in January 2023 and May 2023 had identified works needed to keep people safe in the event of a fire.
- The external fire audit carried out in January 2023 identified several actions, some with immediate responses required. Inspection findings demonstrated a lack of adherence to the risk assessment and a failure to take immediate action as required.
- For example, the independent fire risk assessment highlighted that the survey of the roof space does not support a stay put strategy and therefore the emergency evacuation procedure should be reviewed, and this information communicated to the staff, visitors, and service users. This was an immediate action to be completed. Despite this, staff told us they were not aware of the fire safety action to be taken in the event of a fire.
- Where fire risk assessments identified other storage areas where flammable items should be removed, such as the boiler room and storage cupboard housing electric fuse boards, we found multiple flammable items stored in these areas, including boxes of aerosol cans.
- Fire safety audits had identified works needed to replace intumescent strips on doors through the service which had been painted over. No action had been taken to rectify this and this continued to pose a hazard in event of a fire. We immediately informed the fire safety authority of our findings.
- At our last inspection we identified a lack of action to ensure regular checks on medical equipment including suction machines and blood pressure monitors to ensure these were in working order when needed in an emergency. The provider had failed to take action to rectify this.
- Where people had been identified as at risk of inadequate food and fluid intake, there was a lack of monitoring with records maintained.
- Records of food and fluid intake for people at risk of malnutrition and dehydration and who were known to be losing weight were not regularly completed. Where records had been kept there was no oversight of these.

● Risk management plans for people at risk of choking were ineffective at guiding staff in actions to keep people safe from harm. Where people had been prescribed a thickening product to reduce their risk of choking there was no care plan with guidance for staff to ensure their safety.
● Where staff told us of incidents of people choking on food items, no incident reports had been made with actions planned to prevent a reoccurrence.
● People spent significant periods in sedentary positions without mobilising and there were gaps in repositioning records of up to 9 hours. The failure to follow risk assessments and ensure that people were assisted to reposition at regular intervals placed people at increased risk of skin breakdown.
● Where people had acquired skin tears, had wounds that required regular dressing changes, there was a lack of body maps in use and robust guidance for staff in the monitoring and management of these.
● We found unlocked storage cupboards where people had access to razors, unsecured medicines, cleaning products and toiletries. The risks associated with these items had not been considered.

Using medicines safely
● Where people declined support with administration of their medicines there was a lack of guidance for staff with strategies and actions, they should take to ensure people's health was maintained.
● One person told us, "Twice lately staff have tried to administer someone else's medicines to me. I could tell by the colour of the tablets in the pot they handed to me that they weren't mine. Good thing I could speak up, not everyone here can do that, it could be fatal for someone."
● One relative told us, "One day I found someone else medicines in a pot on a shelf in my [relative's] room. Thankfully the pot was out of their reach."
● At least 50% of staff administering medicines did not have regular competency checks in line with the provider's policy and procedural guidance.
● We found multiple gaps in records of administration for people's prescribed creams and lotions. This meant people had not received their medicines as prescribed.
● During July and August 2023 significant numbers of medicine errors were noted, including where incorrect medicines and incorrect doses had been given to people.
● External medicines and containers of prescribed thickener powder was stored in an unlocked room regularly accessed by people and their relatives. Some had names of people no longer resident in the service.
● Where people required nutritional support via a percutaneous endoscopic gastrostomy (PEG), enteral feeding plans conflicted with daily records with regards to the flushing volumes for the PEG tube. The lack of clarification meant staff were not provided with clear guidance and put people at risk of harm.
● The provider did not have an effective system to check medicines. 2 boxes of enteral feeding water bags were found on shelving. Both boxes had writing on them stating equipment had expired in March 2023.When we pointed this out to the registered manager, they said they were unaware they had expired.
● On the 2nd day of our visit we noted one person was administered paracetamol by two nurses with less than 2 hours in between each administration. This meant this medicine was not administered as prescribed and had the potential to put them at risk of harm.
● The medication administration record (MAR) for one person recorded medicines had been crushed on the 15 September 2023 but had not been transcribed. This meant that this person did not receive their medicines as prescribed for 2 days. The care plan was not updated to describe how and what medicines were to be crushed.
● One person was identified as needing covert administration of medication on 29 August 2023, but this was still not in place at the time of the inspection. Their GP had stated on 12 September 2023 that without their medicines they were at significant risk of harm. The registered manager said the delays were due to a lack of signed paperwork. No action had been taken to ensure this person received their medication putting them at risk of harm. Their care plan had not been updated to reflect any action taken or any interim measures to

ensure their health needs were being met.
● Where people had been prescribed anticipatory medicines at the end of life for anxiety and pain relief, there were incidents where these medicines were not administered as prescribed.

Preventing and controlling infection
● We were not assured that the provider was supporting people to minimise the spread of infection. We found hoists, wheelchairs and pressure cushions in an unclean condition. There was no system in place to ensure regular cleaning of this equipment.
● An audit of the main kitchen carried out by Environmental Health [EHO] Inspectors in May 2023 downgraded the service from 5 stars to 3 stars.
● Not all recommendations and requirements from the EHO inspection had been addressed.

The shortfalls identified in the management of people's medicines and a failure to ensure risks had been fully identified, managed and mitigated demonstrated a continued breach of Regulation 12 [Safe care and treatment] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● Safeguarding systems and processes were not robust to ensure people were always protected from the risk of abuse. The provider had not responded to safeguarding concerns in line with their own policy and local protocols. Appropriate action had not always been taken to keep people protected from the risk of abuse and harm.
● Safeguarding systems and processes were not robust to ensure people are always protected from the risk of abuse. Where people and their relatives had raised some serious concerns to the senior management team about staff practice, they had not responded in line with their own policy and local safeguarding protocols. This meant action had not always been taken to keep people protected from the risk of abuse and harm.
● Given the seriousness of the concerns and our findings we immediately reported this information to the local safeguarding authority.
● Not everyone using the service was able to verbally communicate their wishes and feelings. Systems and processes did enable support for them to raise any concerns or complaints should they have any.

These shortfalls in safeguarding processes placed people at risk of harm and is a breach of regulation 13 [Safeguarding] of the Health and Social Care Act 2008 [Regulated Activities] regulations 2014.

Staffing and recruitment
● The numbers and deployment of staff did not meet the complex and changing needs of people.
● At night we found that there was one nurse and three care staff to support 35 people. Some people expressed concerns about the availability of staff at night. One person said, "You have to wait for them [staff] to answer your call bell." Another said, "It's mostly all agency at night. You have to wait a long time. You cannot understand most of them and they don't understand what you say. I tried to tell one member of staff I needed help to shift up the bed and I gave up asking because they just didn't understand me."
● Staff told us at least 20 of the 35 people living in the service at the time of our inspection required two staff to support with repositioning and personal care including the night time period.
● When nursing staff were asked if they were aware of any dependency tool to assess people's needs against numbers of staff available, they told us, "No, I don't know of any dependency tool if there is one in place." And, "When we have all agency staff on a shift it can be really hard. Some people don't get their personal care until after lunch. The complexity of people's needs changes constantly but the number of staff on duty does not. If there is an assessment of dependency, where is it?"

The provider had failed to ensure there were sufficient numbers of suitably trained and deployed in the service. This placed people at risk of harm and is a breach of regulation 18 [Staffing] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

● Recruitment procedures were not always operated effectively to ensure staff employed met the conditions required.
● A review of recruitment records showed 2 staff where their UK entry clearance records stated as a student, they could only legally work 20 hours per week. Staffing rotas showed these staff working in excess of 60 hours per week.
● Not all references obtained were from the most recent employer as required. For one person both references obtained appeared to be from the same person.
● Not all overseas visa documents were available as required. When asked the registered manager said they did not know why they were not available.

The provider had failed to ensure recruitment procedures were established and operated effectively as required. This placed people at risk of harm and is a breach of regulation 19 [Fit and proper persons employed] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

Visiting in care homes
● Relatives told us they were able to visit freely.

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

- Assessment tools, used to identify the care and support people needed to meet their needs and prevent a deterioration in their health, were in place but not always fully completed.
- Records in relation to people's day to day care were poor, with conflicting information, daily care notes were found with large gaps in recording and care plans not updated to reflect current care and support needs.
- There was a lack of evidence to demonstrate people had access to a bath or shower according to their choice.
- Records of oral care provided were lacking to evidence how this support was to be provided and what if any planned access to dentists.
- We found the majority of toothbrushes in people's bathrooms to be dry indicating they had not been recently used.
- Where people had lost significant weight referrals to specialists for advice were not actioned in a timely way. Specialist advice had not always been transferred to care and risk management plans. For example, the need to ensure more regular weight monitoring.

This demonstrated a breach of Regulation 9 [Person centred care] of the Health and Social Care Act ([Activities] Regulations 2014.

Staff support: induction, training, skills and experience

- The staff training matrix showed none of the care staff employed had received training in recognising and responding to the needs of people living with dementia, choking risks and food hygiene safety.
- Only 10 out of 25 care staff had received training in oral care.
- None of the care staff employed had received training in understanding their roles and responsibilities in relation to the Mental Capacity act 2005.
- Staff lacked the skills and knowledge to respond in the event of an emergency, such as how to respond to fire bells and the outbreak of fire.
- Training records showed not all permanent staff had received training in fire safety and those that had, had not had any refresher training provided since 2021.
- The registered manager told us no records were maintained of agency staff induction.

● Staff told us they were not supported with regular supervision and appraisal. Staff records confirmed this.

The provider had failed to ensure there were suitably trained staff. This placed people at risk of harm and is a breach of regulation 18 [Staffing] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● We observed people cared for in bed without access to a drink.
● There was little evidence of people being offered fortified or healthy snacks throughout the day to increase their calorie intake.
● People, their relatives and staff told us there had been a deterioration in the quality of the food provided since the new ownership of the service.
● One person told us, "I have asked my relatives to bring in food so I can give this to the cooks to prepare for me. There are rarely any decent fresh vegetables." Another said, "The tea time meal is always sandwiches, it just gets boring. We used to have cake in the afternoon with a drink, but this does not always happen now."

This was a breach of Regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

● Many people were cared for in bed. Staff told us this was because they did not always have enough staff to get people up and some people were at risk of falls.
● People's care plans did not always record the reasons why people were cared for in bed. Mental capacity assessments had not been completed for people who were kept in bed where they had been identified as being at risk of falls, to determine their capacity to consent to this. This meant restrictions were placed on people without consent and careful care planning.
● Relatives had complained their loved ones did not always have access to a call bell. We found some people did have access. However, for those who did not, there was not always an assessment as to people's capacity to use a call bell or alternative arrangements in place should they need staff support.

This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Where people had bed rails in situ. MCA assessments had been carried out and reviewed

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

● The provider had taken ownership of the service in 2022. Some decoration of corridors and rooms had been carried out.

● A number of bathrooms were being used to store equipment such as trolleys, hoists, discarded hoist slings, towels, continence equipment and boxes. Staff told us this prevented them from access to these rooms to support people with bathing.

● We found only 2 baths and 1 shower accessible for up to 40 people to access across two floors. People told us there was a lack of regular access to baths and showers and records confirmed this.

● Corridors and doors were all painted white with a lack of signage. This did not support people living with dementia to find their room and orientate around the building. There was no other dementia friendly signage or adaption to support people who could become disorientated.

● Gardens were attractive and well maintained.

Requires Improvement

Is the service caring?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- We saw many positive staff interactions which were respectful, kind, and considerate. However, concerns had recently been raised that staff had not always treated people with kindness and respect. These concerns had not been taken seriously and the provider had not demonstrated in how they have responded to other issues such as fire safety, that people were consistently well treated and respected.
- People told us in the main staff respected their equality and diversity. However, we observed staff refer to people needing support with eating their meals as, 'feeds'.
- One person said, "The staff are mostly very kind, there is the odd one who is a bit rough and some cannot understand what you are saying because and I don't understand what they are saying to me as they don't speak English very well."
- Relatives described incidents of staff acting in an un-professional manner. One relative said, "There is lots of gossiping and complaining amongst the staff and people don't need to hear that." Another said, "The atmosphere has changed, it is not the lovely place it used to be. The staff morale is very low and this affects people who have to live in this home."

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

- People's care records did not document whether they, their relative, and or advocate had taken part in decisions around their care provision. These included reviews of people's, nursing, care, and support needs to make sure they were up to date.
- There was a lack of access to systems to enable people to share their views regarding the quality of care they received.

Respecting and promoting people's privacy, dignity and independence

- The majority of care plans stated people did not have a preference as to gender of staff who supported them with their personal care. However, some people told us they had not been asked and would prefer not to have male staff support them.
- Care plans did not always record how staff should meet peoples identified religious or cultural needs.
- People told us the majority of staff supported their independence and protected their dignity when supporting with personal care.

Requires Improvement

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 requires improvement. This meant people's needs were not always met.

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

- At our last inspection we identified care plans were brief in detail, generic and not personalised to the individual.
- At this inspection we found some improvement but further work was needed. Not all relevant information from other professionals had been transferred to care plans. This meant staff did not always have the guidance needed to ensure they met people's health, welfare and safety needs.
- There were significant gaps in staff daily recording of support provided to people. We found gaps of up to 10 days. This meant we could not be sure people's needs were being met.
- Staff told us people were cared for in bed for reasons other than preference or health care needs. Staff said some people were kept in bed as they were at risk of falling, and other reasons given were a lack of time to support people to get up every day.
- Care plans did not always describe the reasons for people staying in bed.
- One person told us they wanted to get up out of bed to sit in their armchair but the chair had been removed from their room. In response to our feedback the registered manager had another chair installed. However, we noted this person at the end of the day had not been supported to get dressed and out of bed as they had earlier requested.
- A number of do not attempt resuscitation forms [DNACPR] had been completed whilst people had been in hospital, prior to their admission. These had not been reviewed since admission some years earlier.
- People were often admitted to Pinford End to receive end of life care. We found the majority of care plans to guide staff as to people's wishes at the end of life were found to be blank. This meant advanced care planning had not been provided to enable people an opportunity to think about what matters most to them and what level of care and treatment they wished to receive.

This demonstrated a failure to provide appropriate support in a person-centred way. This was a breach of Regulation 9 [person centred care]of the Health and Social Care Act [Regulated Activities] Regulations 2014.

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

- There was one activities organiser employed present on the 2nd day of our visit. We observed activities taking place which people enjoyed. This included some one to one activit5ies in rooms where people were cared for in bed.
- People and their relatives had mixed opinions on whether there were enough activities to keep people stimulated and meaningfully occupied. One person told us, "It can get very lonely. There's not much going on. We do have a lovely activities organiser who does their best but they can't be everywhere."

● Care plans did not provide information as to people's choice as to where they spent their time.
● Staff told us previous funding to enable them to pay for activity materials and organise entertainment had been removed by the provider. They also told us they now had to raise funds themselves. One said, "We have been making something out of nothing. Staff are sometimes funding for activities from their own money."

Improving care quality in response to complaints or concerns
● There was a system in place for logging concerns and complaints.
● 5 complaints had been logged since March 2023. All with similar themes, including a lack of staffing, lack of access to call bells, quality of food, staff conduct and safeguarding concerns. The current system did not look for and act on any trends identified within the complaints logged.

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.

● Basic information about people's communication needs was written in their care plans. Information could be provided in formats to suit individual if needed, although we did not see evidence of this.
● People living with dementia had limited orientation aids available within the service. This increased the risk of people being disorientated because the environment had not been fully designed to meet their needs, such as dementia friendly signage.

We recommend the provider place appropriate accessible signage within the service.

We also recommend the provider seeks guidance from an appropriate source to increase the use of accessible information to meet people's needs.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has 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.

At our last inspection the provider had failed to ensure systems and processes were in place and effective at identifying and mitigating risks to the health safety and welfare of people This was a breach of regulation 17 (Good governance) 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 17.

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

- Systems and processes continued to be ineffective at identifying and mitigating environmental or health and safety concerns as described within the safe section of this report.
- Records had not been maintained to ensure they were accurate and up to date. For example, care plans, risk monitoring and staffing rotas. Staffing rotas did not always reflect the actual staff on duty. Individual names of agency staff were not always entered onto the rota, just the name of the supplying agency.
- The quality assurance systems were not robust. There was ineffective governance and poor oversight at registered manager and provider level which had failed to fully identify shortfalls in the service putting people at risk of harm.
- The shortfalls found at this inspection and those of other professionals had not been identified or actions taken to reduce risks to people's health, welfare and safety.

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

- Prior to our inspection the provider had not informed CQC of ongoing safeguarding investigations as required through formal notification.
- There was a failure to submit statutory notifications to the Care Quality Commission (CQC) as required by law. For example, serious incidents, safeguarding investigations and notifications of deaths in a timely manner.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The provider had failed to ensure people were receiving care that met their individual needs. Care plans were not consistent, accurate or kept up to date to give staff the instructions they needed to provide person

centred care.
● Areas of risk were not being effectively monitored and the health and well-being of people was not routinely assessed.
● Staff told us they felt unsupported and under-valued by the provider and their concerns were not listened to.
● Staff told us, "Morale is very low, it has hit rock bottom." And, "The atmosphere here since the new owners took over is horrible. The focus is on money and not the care of the residents. I have always been proud to work here, we always had a good reputation, but not anymore."
● One staff member said, "The manager is very good, very caring but they can't do it all. They try to do it all themselves but needs help."
● Some staff were visibly upset when talking with Inspectors about their experiences of working at the service. Staff told us they had not received regular supervision, appraisal and staff meetings to share any concerns or suggestions they might have.
● One relative told us, "I have consistently asked the owners of the home to set up relatives meetings so we can share our views and receive updates. This has not happened." Another said, "Every time I raise a concern I am told "it is in hand" but nothing changes. I was never told when the home had been sold with new owners."

The service continued not to be well led. This demonstrated a continued breach of Regulation 17 [Good governance] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

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 People's care and treatment had not been planned to meet their needs and reflect their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent There was a lack of capacity assessments to ensure staff were guided to act within the requirements of the Mental Capacity Act 2005. Staff had not been provided with training to understand their roles and responsibilities in line with the Mental Capacity Act 2005.

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 The provider response to allegations of abuse did not protect people from the risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People did not have their nutrition and hydration needs monitored to ensure they received the support they needed.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to ensure recruitment procedures were established and operated effectively as required.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure there were sufficient numbers of suitably trained and deployed in the service. This placed people at risk of harm.