Cadogan Care Limited

Goldcrest

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

Summary of findings

Overall summary

About the service
Goldcrest is a residential care home providing personal care for up to 26 people. The service provides support to older people living with dementia. At the time of our inspection there were 13 people using the service.

Goldcrest accommodates people in one adapted building in a residential area of Weymouth.

People's experience of using this service and what we found
On the first day of our inspection serious concerns were identified about people's safety. Medicines were not safely managed, people were not helped to move when they needed help, the home was not clean, and staff were not wearing PPE appropriately. CQC liaised with the local authority and the provider to ensure immediate actions were taken to ensure people's safety. An independent care consultant was appointed by the provider to help address immediate concerns and support the newly appointed manager (hereafter referred to as the manager).

There were insufficient trained staff to meet people's needs. We saw people were unsupervised, did not receive their medicines safely, and did not have support to use their time meaningfully. Staff had not undertaken training necessary for them to carry out their roles effectively. Actions were taken following the inspection to ensure staffing reflected the needs of people in the home.

People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support good practice. Actions were taken by the provider to reduce immediate restrictions. There were plans to introduce more choice.

People were not protected from harm of known risks. Risk management systems were not operated effectively, and care plans were not always followed to ensure people were protected from harm. The environment people lived in was not safe or well maintained.

People were not always treated with respect. Whilst staff cared about the people they supported, they spoke about them in relation to care tasks needed and did not always encourage independence.

People's needs had not been reviewed and assessed sufficiently and changes in their needs had not always been followed up with referrals to appropriate professionals. Actions were taken by the manager to address this during our inspection.

Staff knew how to report safeguarding incidents. One allegation of abuse had been reported but not addressed appropriately by the provider.

Quality assurance measures were not effective and had not identified the concerns identified during the inspection.

During the inspection immediate actions were taken and an action plan was put in place. Staff and the manager told us they were committed to providing good, kind and safe care. The provider committed to employing the care consultancy whilst the required improvements were addressed and to develop their oversight of the safety and quality of care people received.

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

Rating at last inspection
The last rating for this service was good (19 June 2018). We inspected, but did not rate, the service in March 2021.

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

The inspection was prompted in part due to concerns received about medicines management, staffing, risk management and governance. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only. During the inspection we identified further concerns about people's experience of care. As a result we widened the scope of the inspection to include the key questions of caring and responsive.

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

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

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Goldcrest 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 monitor the service and will take further action if needed.

We have identified breaches in relation to risk management, person centred care, dignity and respect, staffing, the environment, the implementation of the MCA and governance at this inspection.

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

The information about CQC's regulatory response to the more serious concerns found during the inspection have been added to the report. We served a warning notice and imposed additional conditions of

registration to ensure compliance with the regulations.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not effective.

Details are in our effective findings below.

Inadequate

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not responsive.

Details are in our responsive findings below.

Inadequate

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate

Goldcrest

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.

Inspection team
The inspection was carried out by four inspectors.

Service and service type
Goldcrest 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. Goldcrest is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

At the time of our inspection visits the previous registered manager had left their post and put in an application to deregister.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us

annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection

During the inspection we spoke with eight people living at Goldcrest and three relatives. We spent time observing the care and support people received. We also spoke with the two directors of the provider organisation, one of whom was the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke with the manager and four members of the staff team and an agency member of staff. We also looked at records related to the six people's care, multiple people's medicines administration records, and records relating to the oversight and management of the service. This included four staff files, training records, rotas, risk assessments, internal oversight tools and audits.

Inadequate

Is the service safe?

Our findings

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

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

This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse
● Allegations of abuse raised by a member of staff had not been investigated sufficiently. The local authority safeguarding team and CQC had not been made aware of the allegations. These allegations were raised with the provider but not reported to safeguarding until they were picked up by the local authority quality monitoring team during a visit. This put people at risk of harm.
● CQC inspectors raised safeguarding alerts with the local authority safeguarding team during the inspection as these safeguarding concerns had not been identified by staff working within the home. This placed people at risk of harm.

The shortfalls in the effectiveness of safeguarding systems put people at risk and 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.

●Staff told us they knew how to report abuse.
● During the inspection the home was placed into a whole home safeguarding process due to the nature of concerns about people's safety and wellbeing. A social care professional had also raised concerns about the safety of a person's care prior to the inspection. Safeguarding professionals were looking into these concerns at the time of the inspection.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
● People were at risk of harm because risks were not adequately assessed and measures to mitigate risk were not implemented consistently. This included risks associated with people's skin integrity, mobility and health.
● Staff had varied understanding of how to respond to situations where people were at risk. We saw a person who should be supervised when using a piece of equipment had slipped and was in a dangerous position. This incident was not recorded, and we noted a previous record of a similar incident had not led to action to adequately reduce the risk of reoccurrence. Staff did not know how to respond to a seizure if one occurred, putting another person at risk of harm. An alarm mat and call bell were not in place for one person as specified in their risk assessment. This placed them at a heightened risk of falls.
● Risks associated with eating and drinking safely were not always safely managed. Two people were drinking from cups that were not in line with their safe swallowing plan. This was rectified immediately when notified to the manager.
● Environmental risks had not been appropriately assessed. Wardrobes were not secured to the wall putting

people who were independently mobile at risk as these may topple over. The lift door was open to the ground floor. The floor covering of the lift was uneven and posed a trip hazard for people walking around the home.
● Equipment was not used safely. People slept on beds where the mattresses did not extend the length of their bed. Covers for bedrails were not all full length. This put people at risk of trapping a limb.
● Fire safety checks were not up to date and the information held in the home to assist emergency services in the event of an evacuation was not up to date. A recent visit by the fire service had resulted in required actions to ensure safety.
● A member of staff was accommodated in one of the bedrooms alongside people living at the home. There was not any risk assessment or management plan in place to protect people and the staff member.
● CQC inspectors contacted Environmental Health, during the inspection, due to lack of hygiene measures noted in the kitchen. Staff from Environmental Heath visited, and the home's rating was reduced to one star (the lowest rating) with measures required to improve safety standards.

The shortfalls in risk management placed people at risk and were a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The manager and provider were responsive to all of the concerns raised and started to act to rectify safety issues before the inspection concluded. We were not able to review the effectiveness of these actions during our inspection.
● Following our inspection staff from Environmental Health returned to review the improvements made in food hygiene. They found evidence of improvement and rated the home five star (the highest rating).

Staffing and recruitment
● Recruitment had not been carried out safely. This meant that information required to help employers make safer recruitment decisions had not been sought.

These omissions were a breach of Regulation 19 (Fit and proper person's employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Actions were taken during our inspection to ensure the appropriate information was gathered and recorded during future staff recruitment. We have, therefore, not been able to review the effectiveness of these actions at this inspection.

● Staff were not deployed in a way that ensured people's needs were met and they were safe. There had not been an assessment of staffing levels based on people's needs. People were unsupervised in communal areas when a risk assessment indicated this was unsafe. People did not receive care and support in a timely manner. One person was not afforded the chance to get out of bed because there were not enough staff working.
● Staff competency to give medicines and support people to move in a safe way had not been assessed. This meant enough appropriately trained staff were not deployed to ensure people's safety. This meant healthcare professionals had to come to the home to administer medicines over the weekend following our first visits.

This failure to ensure the safe deployment of staff was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● During our inspection competency checks were commenced and staffing was increased to reflect an

assessment based on people's needs. We have not been able to review the effectiveness of these actions at this inspection.

Using medicines safely

● People were not receiving their medicines safely and as prescribed. Medicines that should have been given when required (PRN) for agitation and pain were given routinely without any protocol available explaining when they should be given. Regular use of PRN should be reviewed with each person's GP to consider if regular medicine would be more appropriate.

● Prescribed medicines were not always given. This included medicines for health conditions and pain management.

● Recording relating to medicines administration was not always completed accurately.

● The oversight of medicines had been ineffective. This meant there were large quantities of unnecessary medicines in the home. Some of these medicines had passed their use by date. This put people at risk of receiving medicines that were out of date.

● Some medicines were not stored in line with legislation.

● People did not always receive their medicines at the time they should. One person commented that the time of their medicines was "a bit spasmodic".

The shortfalls in medicines administration put people at risk and were a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● During the inspection the provider arranged for staff competency in relation to medicine administration to be assessed.

● Prior to the inspection the new manager had contacted health professionals about reviewing people's medicines.

Preventing and controlling infection

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. We identified areas of the home that had not been adequately cleaned including communal areas where there was no increased cleaning of regularly touched points.

● We were not assured that the provider was using PPE effectively and safely. Whilst, the use of face masks improved during our visits we noted a staff member in close proximity to people living in the home without a mask on the last day we visited.

● We were assured that the provider was preventing visitors from catching and spreading infections.

● 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 accessing testing for people using the service and staff.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

We have also signposted the provider to resources to develop their approach.

Visiting in care homes
The provider was supporting visiting in line with national guidance.

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.

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.

- DoLS had been applied for, however where people were actively wanting to leave the home the appropriate authorities had not been made aware so they could prioritise a review of the person's deprivation of liberty. CQC contacted the relevant authority during the inspection about three people who were actively trying to leave. A member of staff commented "If we let her out, we will never get her back" about one person.
- Internal doors were used to restrict people's movement without appropriate authority. A relative described how they had been locked in a room with their relative and two other people. They told us this had also happened to the person's friend when visiting.
- A local authority quality monitoring visit in May 2022 identified a lounge door had been locked without appropriate decision making or authority.

These restrictions were 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.

- Measures were put in place to remove the use of door locks where they were not necessary for people's

safety following our inspection. A matrix of DoLS applications was put in place to ensure oversight of applications and changes in people's response to living in the home could be monitored. We have not been able to review the effectiveness of these measures at this inspection.

● Where people were able to consent to aspects of their care this was not always recorded or sought. We observed people receiving care and support that was provided without consent being established.
● Care plans had not been drawn up in consultation with people or those they had granted the legal status to make decisions for them. This meant there was no evidence of how decisions had been made in consultation with others and in people's best interests.
● One person's care plan described how they could be given medicines without their knowledge. There was no evidence to show the person's capacity to give, or withhold, consent had been assessed and people who knew the person well had not been consulted. This meant there was a risk this was not the least restrictive approach.

Staff were not following the Mental Capacity Act 2005 principles and Code of Practice. This is a breach of Regulation 11 (Need for consent) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● The induction process was not adequate. One member of staff had returned to the home after leaving for two years. They had not undergone any induction process to refresh their knowledge and skills.
● People were not always supported by staff who fully understood their needs or how to meet them. The majority of people at the home were living with dementia and some people could therefore become distressed. Approximately half the staff team had not received training or guidance in best practice in supporting people living with dementia and how to respond to distress. Our observations showed some staff did not engage well with people to promote their well-being. One person was unsettled during a time of the day when they often wanted to leave the building. We saw a member of staff continually asked them to sit down in the lounge. They were not supported in a way which provided any distraction.
● Most staff had not received training on the importance of oral care and we gathered evidence that people's oral care needs were not well supported.
● People were cared for by staff who had not all received training to enable them to safely support people. Some staff had not updated their safeguarding training in line with the provider's policy. Moving and Handling training had not always been refreshed and competency had not been assessed. Medication competency had not been assessed.
● Staff had not been receiving regular supervision sessions. This meant there was a risk that competence concerns and professional development issues were not addressed.
● Training had not been reviewed in line with people's assessed needs. For example, staff had received training in caring for people who had epilepsy after a monitoring visit from the local authority identified staff had not received this. Staff had not received training about learning disability when a person with a learning disability moved into the home.

This failure to ensure appropriate training and support was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The new manager was identifying training opportunities and supporting staff to undertake appropriate training.
● A plan was actioned to ensure staff competency related to medicines administration and supporting

people to move safely. We have not been able to review the effectiveness of this action plan at this inspection.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● Assessments of people's needs were in some instances minimal and did not reflect their views or the views of people who knew them well. Each person had a care plan which set out their main needs. Some care plans contained minimal information to enable staff to meet their needs in a planned way. For example, care plans did not give detailed information about how best to support people with personal care. This placed people at risk of receiving inconsistent care and support.

● Care plans did not always reflect the care people received because their needs had changed, and no further assessment had been carried out. For example, one person had been cared for in bed for a number of months. Their care plan still reflected the way they were supported with mobility and out of their bed. The failure to undertake another assessment meant the person was at risk of receiving inappropriate care. The manager acknowledged that care plans needed to be reviewed to ensure they were accurate and relevant.

● People and relatives told us they had not been asked to provide detail about likes, dislikes and wishes. People's likes, dislikes and lifestyle choices were not comprehensively recorded. This meant that staff did not have the information they required to provide personalised care to people. Therefore, people were at risk of receiving care which was not in accordance with their personal values, beliefs and wishes.

● Staff had limited information about how best to support people when they expressed anxiety or had low mood. Care plans referred to mental well-being but did not contain guidance about what helped people calm when anxious or how to address low mood.

● People's oral health care needs had been assessed and were described in their care plans. On the first day of our inspection we identified three people who did not have the toothbrushes/toothpaste/swabs they needed for oral care available. Records did not reflect oral care being prompted or provided as their care plans indicated.

These omissions in assessment and appropriate care delivery were a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● One relative told us they had previously been asked information about their loved one.

● Care plans were being reviewed and relatives and people were asked to contribute to these reviews.

● People had access to toothbrushes and toothpaste after our first visit. Recording of support improved but remained sporadic for the following week.

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

● People who needed support to eat and drink were supported by staff who were kind and familiar with the person they were supporting. At lunch time we observed staff took time to help people who needed physical support to eat.

● People had no choice of meals. The manager told us they planned to introduce this. On the days we visited most people appeared happy with the meal they were given and ate well. However, records indicated that sometimes people did not eat what was offered and this led to a limited choice. For example, one person was recorded as disliking the soup offered and after one spoonful they refused. They were not offered any savoury alternatives and ate two mousses. Information about this person's food preferences had not been transferred from information that had been recorded about them before they moved into the home.

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

● People saw healthcare professionals according to their individual needs. The home was supported by the frailty team and had a weekly regular opportunity to raise non urgent matters and identify the need for reviews.
● People had not always been supported to seek input for long term situations. During the inspection we identified a monitoring appointment that had been cancelled and not followed up. We also identified two situations where health professional's advice was still required regarding equipment for safety and well-being. These were situations that had been ongoing over a period of months.

These failures to support people to access appropriate support were a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Appointments were made with professionals to address the issues identified.

Adapting service, design, decoration to meet people's needs
● People lived in a home which was not well maintained. This had resulted in actions required by both the fire service and environmental health.
● Decorative work was necessary to ensure that cleaning could be carried out effectively.
● Whilst there was some signage in the home, it had not been assessed to ensure it was dementia friendly. This meant people who walked with purpose did not have focal points where meaningful activity was available. This also meant that people's rooms and the toilets were not easily identifiable.
● The home had a garden that we were told needed some maintenance work before people could use it safely.
● The lift door was open to the ground floor. The floor covering of the lift was uneven and posed a trip hazard for people walking around the home.
● The carpet was worn in some places and the flooring in the kitchen needed to be replaced.
● The patio doors were not working properly. A person commented that they were 'freezing' wanted them closed and they couldn't be because they did not work properly.

The failure to maintain the environment was a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The consultant brought in to support the manager described how important it was to consider people's sensory needs associated with their dementia in the environment. We were involved in a discussion about improving the garden in ways which would support people with dementia.
● An action plan had been put in place to ensure health and safety of the premises was assessed and improved. We were not able to assess the effectiveness of this plan during this inspection.

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.

Respecting and promoting people's privacy, dignity and independence
● People were not always treated with dignity and respect. We observed staff talking in communal areas to other staff without discretion about support people needed with their continence. These comments referred to the task staff were carrying out. For example, a member of staff referred to a person needing "draining off" another member of staff spoke loudly about "toileting" the person they were walking with through the lounge.
● People were not supported to maintain skills they had. We observed a member of staff put cups to people's mouths and tip drink in without speaking to the people receiving the drink. At other times we had seen these same people were able to hold cups and drink independently. This did not show respect for people's dignity or promote their independence.
● There were toiletries in a bathroom that could be used by anyone using the bathroom. This did not respect people's individuality or preferences. This reflected a task focussed approach to personal care that did not promote people's dignity or individuality.

People were not always treated with dignity and respect. This was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The consultant told us they would be coaching staff in how to care for people with dignity and respect. The manager told us they had identified some shortfalls in agency staff skills and a new agency had been identified who could provide staff who had more skills and experience.

Ensuring people are well treated and supported; respecting equality and diversity
● Most staff were kind to the people they supported, and we saw some compassionate, kind and skilled care. We also saw staff provide care that did not respect the individuals they were supporting.
● People's relatives and friends were able to visit when they chose. We heard feedback this had not always been the case. Two relatives said they felt a positive change in how welcoming the home felt.

Supporting people to express their views and be involved in making decisions about their care
● People were not always asked to make choices about their day to day life. One person who liked to get up and spend time in communal areas was sometimes not asked if they would like to get out of bed so remained in bed without being asked.

● We saw mixed evidence of people being offered choices such as what they would like to drink. People could not reliably expect to be given this choice. People were also given clothing protectors when having meals and drinks without being asked if they wanted to wear them.
● Staff did not always consult people when they put music on in the lounge area. They also did not check people were happy with silence when the music had finished.

These omissions in supporting choice were a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

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

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

This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People were not receiving responsive, personalised care. Staff told us the care plans needed updating and due to an error in set up some agency staff could not access everyone's care plans on the electronic handheld devices staff used. We identified examples of care being provided in ways that did not reflect the person's care plans or their presenting needs. One person's care plan identified staff were to ask them regularly if they wanted to go to the toilet and then assist them if they needed to. They also had a health condition that involves pain if mobility is not maintained. We observed they were not offered to move out of one chair for periods of four to seven hours. Another person used a continence aid which their care plan detailed should be drained at one and a half hour intervals. We observed this aid was full on two days of our visits and records showed it was regularly not drained for more than three hours. On one occasion a member of staff noticed it was full and told other staff it needed to be emptied. This was not done for a further hour and a half putting the person at risk.
- Care reviews had not been undertaken as people's needs changed. One person's care plan had not been reviewed since before a time when they were very unwell and could not leave their bed. A relative explained this was months ago. Their care plan still referred to them getting up but their relative told us this had been deemed unsafe as they leaned to one side in a chair. No review of this had been carried out as their health improved and they had remained being cared for solely in bed. This person was not receiving responsive person-centred care.
- Some people had personal history information available from previous places they had lived. This had not been transferred to care plans that staff had access to. We noted one person's preferred name was recorded but staff called them by their full name. We checked with a relative who confirmed they preferred the shortened version and explained the full version was the name they would associate with being in trouble.
- Established staff did not know about information in the care plans. One member of staff told us they had not known a person had epilepsy until the new manager started work in the home at the start of July 2022. This information had been available in their care plan prior to the new manager starting.
- A person told us they had never been asked about things they enjoyed doing. They told us something they would like to do which we shared with the manager. In a subsequent visit by a health professional they shared a style of dance they liked to watch. This was then arranged for them. Another person's family provided feedback to professionals that their loved one enjoyed art and puzzles. They had brought the materials needed to the home but had never seen their loved one using them. The person's care plan said they like to watch activity rather than join in. We observed this person sitting passively and withdrawn for

long periods of time without social interaction. These people were not receiving person centred care because their views and the views of their loved one's had not been valued, sought or acted upon.
● During our visits people spent long periods of time without anything to do. The music in the communal lounge was not always playing and there was no television for communal viewing. People who did not spend their time in the main communal lounge spend long period of time alone in their rooms or in the second lounge.
● Recording about activities made it hard to review how people had spent their time and whether they had enjoyed it. Daily records did not usually refer to what people had been doing to pass or provide meaning to their time. This meant it was not possible to review people's experience of activity.

People did not receive care that reflected their needs. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff told us they spoke with each other about people's needs. They told us they received a handover before each shift started to ensure they were aware of any changes. Inconsistent and inaccurate record keeping did not support the effective hand over of information.
● Staff were starting to undertake a review of people's needs alongside the new manager. Relatives told us they had been asked to contribute to this process.
● A member of staff was allocated a role focussed on improving activities during our inspection. We have not been able to review the impact of this during this inspection.
● Following the inspection we received feedback from professionals and the manager about the positive impact for people of work done to ensure people's needs were appropriately assessed and responded to.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● People's basic communication needs had been assessed and details of any specific needs were recorded. For example, information about the use of glasses and hearing aids, which enhanced communication, was recorded. One person told us they had hearing aids and there was reference to these in old paperwork. We did not see these in use.
● We observed a member of staff using two drinks to support a person to make a choice between different flavours of squash. Pictures, signage and objects of reference were not used regularly to support people's communication.

We recommend you review good practice guidance in relation to adapted communication strategies to support people to contribute more to decisions about their days and how their care is delivered.

Improving care quality in response to complaints or concerns
● The provider had a complaints policy.
● A complaint in August 2021 had been addressed appropriately by the provider. A complaint in May 2022 was an allegation of poor practice and was not shared appropriately with safeguarding professionals or the CQC. There was no record that concerning comments in the response of the member of staff who had allegations made against them were followed up. These comments indicated training needs and safety checks on equipment were necessary. The complaint was not managed safely and did not lead to an improvement in the quality of care people received.

End of life care and support

- People had not all been given the option to make end of life care plans.
- We read compliments from relatives of people who had received end of life care at Goldcrest in early 2021. They referred to the kindness shown by staff and good communication by the staff team.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- CQC had not been notified about an allegation of abuse and changes to the organisation's statement of purpose when people with specific needs moved in. There is a legal requirement that the provider update their statement of purpose which sets out their aims and objectives and the type of services they provide. This meant CQC were not aware of poor care practice and changes in the type of support staff needed to provide.

This failure to submit statutory notifications was a breach of Regulation 18 (Notifications) of the Health and Social Care Act 2008 (Registration) Regulations 2009.

- People did not live in a home where the quality of care and support was monitored in a way that had led to improvement in the quality and safety of their care.
- The provider had undertaken regular visits that included walk rounds of the home. The registered manager had told the local authority monitoring team they were struggling to carry out their oversight tasks due to staff shortages. The oversight in place had not led to action to improve people's experience or their safety. For example, an audit of medicines administration carried out in May 2022 had not identified that staff had not been competency checked, out of date medicines or over stocking of medicines all of which would have been present at this time. An audit of accidents and incidents carried out at this time did not refer to a person slipping from their chair. This meant people had remained at risk of harm and had not experienced good quality care.
- The organisational policy on quality assurance referred to tools that were in use to review people's experience. This policy was not being followed as these tools were not being used.
- Requirements made by the fire service about storage under stairs and flammable decorations in corridors had not been actioned.
- An action plan had been submitted to CQC and the local authority outlining actions taken in response to the local authority visits in May 2022. This action plan was not accurate and indicated that actions that had not been addressed were completed. The action plan stated actions related to safe recruitment had been actioned. We found a member of staff had been appointed since this plan without appropriate checks. This member of staff had previously worked in the home but had not worked in social care for 2 years. The action plan stated that all staff wore PPE appropriately. We observed this was not the case. The action plan stated that monthly accident and incident audits had been implemented. We found this had not been achieved. This meant people had remained at risk of harm and had not experienced good quality care.

● Weekly fire safety checks had not been completed since 7 July 2022. This put people at risk of harm.
● We identified multiple examples of omissions and inaccuracies in the reporting of care delivery. This meant it was not possible to review people's care and safety incidents effectively.

These failures to monitor safety and quality and maintain accurate records were a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider appointed an independent care consultancy to lead improvements and support the manager during the first day of our inspection. They responded to immediate risk and implemented a service development plan. We have not been able to review the impact and sustainability of this plan.
● The previous registered manager applied to deregister prior to our inspection. They were deregistered during the inspection process. The provider had appointed a new manager who planned to register with the CQC.
● Training was underway to enable the manager and staff to use the electronic recording system accurately and effectively.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Surveys and discussions had not been carried out to gather the views of relatives and people who could contribute their views verbally. Systems, such as observation, were not in place to regularly check on people's experience of the care and support they received when they were not able to express themselves verbally.

These failures to monitor safety and improve quality were a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● An inclusive and empowering culture had not been present in the home. People were not always offered choices. For example, at lunch time people were served plated meals. They did not have a choice of meal, portion sizes, accompaniments or condiments. People were not always offered the chance to move between different parts of the home. People who could not move without assistance spent long periods of time without the opportunity to influence what happened during their day.
● People were supported by staff who often provided care in a task led way. Whilst some staff appeared to know people well on the days of the inspection, they were often focussed on providing physical care for people. This had an impact on interactions. For example, staff were largely absent upstairs where two people spent the day in their rooms. Staff often spoke with each other about people in ways that focussed on the task they needed support with rather than involving the person.
● Staff and relatives told us they felt positive about the changes that were happening in the home. Staff felt involved in these changes and were hopeful about the home's future.

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
● It was not clear that people and their loved ones had been told when things had gone wrong. We received feedback from a relative who had not been informed about incidents involving their loved one. A person had not been spoken with about what had gone wrong following an accident involving equipment staff used to support them.

● Families had been sent a letter outlining that concerns had been identified during our inspection. The provider told us they planned to discuss these concerns fully at a scheduled event in the home.

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	Regulation 18 Registration Regulations 2009 Notifications of other incidents Statutory notifications had not been submitted to CQC in line with guidance.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not treated with dignity and respect. They were not supported to maintain independence.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's consent to care had not been sought. Where people could not consent to their own care the MCA code of practice had not been followed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems had not operated effectively to identify and protect people form abuse. Restrictions on people's liberty ah d not been appropriately identified.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 15 HSCA RA Regulations 2014 Premises and equipment

The premises were not properly maintained, secure and clean.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's needs were not adequately assessed. Care was not designed to ensure it met people's needs and preferences.

The enforcement action we took:

We have imposed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not receive safe care and treatment. Risks were not adequately assessed. Risk assessments were not followed. People did not receive their medicines safely. People were not protected from the risk of cross infection. Environmental risks were not managed safely. People were supported by staff who had not undertaken appropriate training to ensure people's safety.

The enforcement action we took:

We served a warning notice on 16 August 2022. The provider must be fully compliant with the regulation by 17 October 2022.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not operated to assess and improve the safety and quality of peoples care. Records were not accurate. People and their relatives had not contributed to the quality assurance process.

The enforcement action we took:

We have imposed a condition on the provider's registration.