Roseberry Care Centres (England) Ltd

Hamilton House Care Home

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

Summary of findings

Overall summary

About the service
Hamilton House Care Home is a nursing home providing personal and nursing care for up to 46 people. At the time of the inspection there were 30 people living at the service. The home was over three floors all accessed by a lift. Some rooms were en-suite and for those that were not, there were communal bathrooms and toilets available.

People's experience of using this service and what we found
People and relatives were accepting of the care provided. However, they gave us examples of how the staffing levels impacted them and resulted in delays to their care.

Risks to people were not mitigated and there was no evidence of learning from incidents to prevent reoccurrence and promote safe care. People's medicines were not given as prescribed and changes in their health needs were not responded to in a timely manner.

Sufficient staff was not provided, and staff were not suitably inducted, trained and supervised in their roles to promote safe and effective care.

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

The service was not suitably maintained, fit for purpose or hygienic. Person centred care was not provided, and people did not have access to a range of activities to meet their needs.

The service was not effectively managed and monitored to ensure safe, effective, caring and responsive care was provided. Records were not accurate, complete and contemporaneous.

Systems were in place to manage complaints. Staff were suitably recruited. People described staff as kind and caring, however some staff practice did not promote people's privacy, dignity and choices. We have made a recommendation for the provider to address this.

People's nutritional and hydration needs were identified but not consistently met. We received mixed feedback on the meals provided and have made a recommendation for the provider to seek advice from a reputable source to address this.

Systems were in place to safeguard people, however practices needed to improve to ensure procedures were followed to safeguard people. We have made a recommendation for the provider to work to best practice in relation to safeguarding.

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

Rating at last inspection
This service was registered with us on 13 May 2020 and this is the first inspection. The last rating for the service under the previous provider was good (published on 3 September 2019).

Why we inspected
The inspection was prompted in part due to concerns received about people's care, which included concerns that the service was not responsive to changes in people's health. A decision was made for us to inspect and examine those risks.

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.

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.

Enforcement
We have identified breaches in relation to management of risks, medicine practices, induction and training of staff, staffing levels, record management, person centred care, hygiene and environment, auditing of the service and failing to work to the principles of the Mental Capacity Act 2005.

Full information about CQC's regulatory response to more serious concerns found during the inspection are outlined at the end of this full report.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, including progress with the action plan, 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 always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

Hamilton House Care Home

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was carried out on day one by three inspectors, one whom was a medicine inspector. Two inspectors, a specialist advisor (whose speciality was nursing) and an Expert by Experience visited on day two. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. Two inspectors visited the service on day three.

Service and service type
Hamilton House Care Home is a 'care home' with nursing care. 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. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service is required to have a registered manager. At the time of the inspection there was no registered manager in post. An interim manager had been appointed and was due to start later in March 2022.

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
We spoke with sixteen people who used the service and three relatives. We had discussions with the regional operations manager, deputy manager, the agency nurse, maintenance staff member, cook, registered nurse, two care home assistant practitioners (CHAP's), senior carer and two care staff. We observed mealtimes in different parts of the home, part of a medicines round and part of an activity.

We looked at a range of records. These included 13 care plans, four staff recruitment files, staff training matrix and staff meeting minutes. We checked a sample of internal audits, records of complaints, accident and incident reports and records relating to health and safety, fire, maintenance and upkeep of the premises.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

After the inspection
We sought clarification about some of the evidence we found and reviewed information we asked the provider to send to us after the visit.

We contacted relatives by email, to invite them to provide feedback. We received written feedback from three relatives.

Inadequate

Is the service safe?

Our findings

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

This is the first inspection of this newly registered service. This key question has been rated Inadequate: This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

● Risk management was not effective in mitigating risks. A person had a choking incident on the 17 February 2022. Their choking risk assessment was updated which showed they were a high risk of choking. Whilst the GP was informed no other action was taken to mitigate the risk. On day two of the inspection we observed the person was provided with a normal diet, which was a steak pie. The staff member who took the meal to them was not aware of the choking risk and the kitchen staff had not been informed that a change of meal was required. This placed the person at risk of choking.

● Risks around skin integrity were identified, however records showed people were not repositioned at the frequency required to mitigate the risks to them. The care plan of a person with a grade two pressure sore, acquired whilst at the service indicated they were to be repositioned two hourly. The positional change record contradicted this and indicated the frequency of turns was four hourly. The records showed the person was not repositioned two hourly to mitigate risks to them and on many occasions, there was more than four hours between turns. On the 16 February 2022 there was eight hours and forty-five minutes between repositioning, on the 22 February 2022 there was five hours, and, on the 24 February 2022, there was five and a half hours. The care plan for another person with a pressure sore did not outline the frequency at which the dressing was to be changed, therefore there was variances in the frequency at which the dressing was changed. On one occasion there was a seven-day gap between the pressure area being redressed. Therefore, the measures in place to mitigate the risks of further pressure area damage was not implemented.

● A person's fluid chart viewed over a period of twelve days showed eight days where the target fluid was not reached, and two days where the target fluid was exceeded. Action was not taken to mitigate the risks of dehydration or exceeding the fluid intake.

● Environmental risks associated with high water temperatures, lifting door threshold strips, fire doors not closing, or slamming shut, storerooms containing electrical equipment and hazardous materials unlocked were not identified and placed people at risk. We recorded the water temperature in the hand basins of a communal bathroom as 45 degrees centigrade and the hot water tap in another bathroom, was 48 degrees centigrade on day one of the inspection and 49 degrees centigrade on day three. Two sets of taps were fitted the wrong way around which further increased risks of scalding to people. On day three of the inspection we found a staff toilet door on the second floor was unlocked and accessible. The water temperature of the hand basin tap measured at 56 degrees centigrade which is 12 degrees centigrade higher than the safe temperature recommended. This placed people at risk of scalding.

● A coded padlock had been placed on the garden gate; this gate provided access from the conservatory via the garden into the car park in the event of a fire. The fire action plan stated, "The garden has been fitted with a combination lock to allow easy egress from the area as recommended by the fire risk assessor. All staff are aware of the code." Five staff members spoken with which included the deputy manager, regional

manager, a registered nurse and two carers were not aware of the code, which would delay a speedy evacuation from the service in the event of a fire. No simulated fire evacuations had taken place as previously recommended by the fire service, and no training practice was recorded as taken place on the use of fire evacuation aids. This placed people at risk in the event of a fire.

Risks to people were not mitigated which resulted in safe care and treatment not been provided. This was a breach of regulation 12 (1),12(2)(a), 12(2)(b), (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately after the inspection with an action plan to address the immediate concerns to mitigate risks to people.

Using medicines safely

● Safe medicine practices were not promoted. Whilst most people had one or more medicines prescribed to be administered when required (PRN), we found not all PRN medicines had protocols in place. When PRN protocols were in place, we found that these did not always include enough information to ensure the medicines could be given safely. For example, they did not always specify when these medicines should be given or when additional professional advise should be sought. Alongside this a person's Zopiclone medicine prescribed as PRN (with no protocol in place) was administered daily from the 7 February to 27 February 2022. Staff had not completed the back of the medicine administration record (MAR) to record why it was administered and they had not identified that it was PRN, given daily and had not raised it with the person's GP. Therefore, we were not assured that staff would consistently assess the persons need for 'when required' medicine required administration.

● Some people were on medicines that required to be given at specific times of the day to ensure effectiveness of the medicine. However, we found that these medicines were not always administered at the prescribed times. During the inspection we observed the morning medicines prescribed at 8am was administered at 11am and the 12pm medicines were administered at 2.30/3pm. A person was administered their Parkinson's medicine at 2.30pm instead of 12pm. When the time of actual administration of medicines were different to the directions on the MAR, staff did not record the actual time of administration. Therefore, we could not be assured that people had the appropriate intervals between each medicine administration for the medicines to be effective and safe.

● Whilst most medicine administration records (MAR's) were printed by the community pharmacy, local handwritten MAR's were produced by the service where a dose was changed midcycle or a person was staying for respite care. However, transcribing of the MARs did not always match the directions on the dispensing labels on the medicines. Information to support different directions on MARs were not evident in care plans and therefore we could not be assured that staff were administering medicines as intended by the prescriber.

● Staff were not always recording when medicines were administered in line with Managing medicines in care homes, Social care guideline (Published: 14 March 2014). For example, on the day of inspection we found one person did not have a current MAR in place and staff were not sure if medicines had been administered to them that day. This placed the person's health and well-being at risk from not having their prescribed medicines.

● Medicine care plans did not always have accurate and adequate information related to medicines. For one person there was no information in their diabetes care plan about the prescribed insulin and glucose gel. This meant there was a risk staff may not be able to support people's medical and health needs effectively. Another person smoked and was prescribed flammable creams to be applied 3 to 4 times a day. The flammable risk associated with its use was not identified and managed.

● People told us there was a delay in them getting their medicines. People commented "I take sleeping

tablets; they should be given to me at 8pm. The timing is ok usually, but it has been as late as 9.30. I have anxiety and that does not help when they are late. The home should be aware that they are time critical," and "I have an overnight medication and it has been up to an hour late, I thought maybe they have missed me, but they hadn't."

Safe medicine practices were not always promoted. This was a breach of Regulation 12(2)(g), (Safe Care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Systems were in place to record medicines received, administered and disposed of. Stock checks of medicines took place and temperature checks were maintained of the medicine cupboard, fridge and the room medicines were stored in.

Learning lessons when things go wrong

● The systems in place to promote learning when things go wrong was not effective. A person had three falls in close succession and later it was discovered they had sustained an injury. The service completed a lesson's learnt exercise. The findings showed accident reports were not completed and signed off at the time and there were gaps in daily records which made it difficult to fully establish the facts of the accident. However, an investigation was not carried out and the measures put in place to ensure lessons were learnt were not implemented as other incidents that occurred after this date were not signed off by a senior staff member and gaps in record keeping were not addressed.

● A recent compliant had raised issues about their family members care, the cleanliness of the service, staffing levels, training of staff, lack of effective management and poor communication. Whilst the compliant was investigated by the provider and the outcome of their investigation sent to the complainant, no action was taken to prevent reoccurrence. We found similar issues at the inspection which further supports lessons were not learnt and measures were not put in place to address short falls in the care provided.

Systems were not established and effective to promote learning from incidents to prevent reoccurrence and promote safe care and treatment. This was a breach of regulation 12(1), (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Sufficient numbers of suitably trained staff were not provided, and the high use of agency staff led to inconsistent care for people. Throughout the inspection we saw people did not get the care they required in a timely manner. One person was distressed and at 12.30pm told us they had been waiting since 8.30am to get assistance to get dressed. Another person was calling out for assistance to use the toilet but there was no staff available to assist. When we managed to locate a staff member the person was found to be incontinent.

● There was no oversight of the staff on shift which resulted in staff not being on the floors they were allocated to. Staff breaks were not organised and scheduled so that sufficient staff cover was provided when staff were on their breaks. At lunchtime on both days there was no staff available on the first and second floor to supervise and encourage people with their meals. Throughout the inspection the call bells rang regularly and on one occasion we noted it was ringing for up to 20 minutes. Whilst we were reassured call bell audits took place this was not effective in identifying the length of time call bells rang for or specific times of the day to enable appropriate action to be taken. A person told us they had a fall, rang the pendant alarm, got no response and had to telephone the service to get assistance. Whilst they did not injure themselves, the system in place to summon help was not responded to by staff to promote their safety.

● Staff told us staffing levels were not sufficient. A staff member told us a number of people required two staff for moving and handling which resulted in no staff on the floor when two staff were supporting people.

The pressure of the high use of agency staff impacted on the permanent staff as it meant they were having to complete more tasks due to agency staff not been familiar with role and responsibilities.
● The provider confirmed the staffing levels on each shift was based on the current occupancy. The rotas viewed from the 7 February 2022 to the 1 March 2022 showed six day time shifts where the required care staff was not provided, seven days shifts where a nurse or a care home assistant practitioner (CHAP) was not provided and two night shifts where a care worker was not provided. The provider confirmed the deputy manager covered shifts when a nurse or a CHAP was short on the rota however, the rota did not reflect that, except for one-night shift where the deputy manager covered a night shift on the three-week rota viewed.
● People told us the staffing levels were not sufficient. People commented "The trouble is that they are short staffed, sometimes you have to wait a long time for a response to the call bell", "I think staff are stressed themselves. They are short on numbers and they are often late, my meals are usually delivered a bit late," "I wear my call pendant all the time and use it often. I have had mixed responses with having to wait. I do have to wait sometimes, maybe 20 to 30 minutes, but I know they will come when they can," and "When I'm in bed I need to be moved regularly, each time it should be two carers doing the turning but that is often a challenge for them and I have to wait longer periods for them to come."
● Relatives commented, "The carers do a very good job, but they are very stretched, I suppose I come and visit as the cavalry coming to the rescue."

Sufficient numbers of staff were not provided. This was a breach of regulation 18(1), (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider confirmed in response to the draft inspection report that the recruitment and retention of staff had been challenging as a result of the pandemic, compulsory vaccinations of staff and the impact of Brexit. However, they were committed to recruiting permanent staff to improve continuity of care to people.

● Systems were in place to ensure people were protected as far as possible from unsuitable staff. Checks included Disclosure and Barring Service (DBS) checks, written references, health declarations, and proof of identity and of address. Where there were gaps in candidate's previous employment histories overall these were explored and recorded.

Preventing and controlling infection
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. Whilst cleaning schedules were in place, the service was found to be unhygienic and not suitably cleaned, with a malodour on the first and second floors of the service. This had the potential to increase the risk of cross infection in the service.
● We were somewhat assured that the provider was making sure infection outbreaks can be effectively prevented or managed. During the inspection, a person was barrier nursed on return from hospital. This was precautionary until the service had reassured themselves, the person had not contacted COVID-19. However, during the inspection there was confusion amongst staff as to whether the timeframe for barrier nursing had come to an end with some staff believing the person was still requiring barrier nursing and other staff telling us it had ended. Throughout the inspection there was a sign on the door to indicate the person was barrier nursed however, their bedroom door was consistently left open which made barrier nursing ineffective.
● We were assured that the provider was preventing visitors from catching and spreading infections. On our arrival at the service, we were asked for proof of the result of a lateral flow test, had our temperature taken and were asked a series of questions.
● We were assured that the provider was using PPE effectively and safely. During the inspection staff were wearing masks and used gloves and aprons when supporting people with personal care. Some agency staff

needed reminding to wear the mask on their nose.
● 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'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

Visiting was taking place, with visits booked in advance and visitors were required to carry out a lateral flow test on the day of the visit. Essential care givers were involved, at the time when visits to care homes were restricted.

Systems and processes to safeguard people from the risk of abuse
● Systems were in place to safeguard people from abuse. The provider had safeguarding policies and procedures in place, with the whistleblowing policy displayed on the communal notice boards.
● The provider had provided safeguarding training to staff. However, their training records did not demonstrate that all staff were trained in safeguarding as the list of staff provided to us who had completed the training did not correspond with the training matrix, staff list and rota. This meant we could not be certain all staff attended the training and knew how to respond to a safeguarding concern. In the previous 12 months prior to the inspection we received one safeguarding notification from the service. On review of records we saw an incident that occurred on the 19 February 2022 had not been reported to us and a retrospective safeguarding notification was made.
● A relative told us their family member had been told by night staff 'not to keep pressing their bell'. This practice did not safeguard the person.

It is recommended the provider works to best practice in relation to safeguarding people.

● Staff told us they were clear of their responsibilities in relation to safeguarding people and people told us they felt safe. People commented "I am very safe here, because staff know me. I feel it is good to know that people can chat to you," "I do feel safe here, I don't worry at all. My sons who live nearby explain all to me," and "I feel safe, absolutely, I do so because I know someone is always here and they will come if I need them. I sleep safely, I'm in the right place, although I have not been out anywhere for over six months."

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.

This is the first inspection for this newly registered service. This key question has been rated Inadequate: This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

● Staff were not suitably trained, inducted or assessed to carry out their role. Staff in senior carer roles and the maintenance staff member were not provided with role specific training. The Staff training and Development Policy states "The Company's Induction Training Programme for new care employees (who are also new to care), will include completion of the Skills for Care 'Care Certificate' framework." The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme]. Staff completed the care certificate online training, but no assessments were completed as part of the care certificate training. Therefore, the provider had not assured themselves that staff understood the training and were competent to apply it to their roles.

●The service used care home assistant practitioners (CHAPs). CHAPs bridge the gap between the role of a care assistant and a nurse, allowing them to provide additional support to care home nurses. While they are not registered practitioners like nurses, their high level of training allows them to carry out a lot of the same tasks. The CHAPS were transferred to the current provider at the point the provider took over the service. However, they had no records on file to evidence the CHAP's had completed the relevant training and the provider had not assured themselves that the CHAPS were suitably trained and competent for the role. The regional manager told us they had not yet provided training for the CHAP's to complete, neither had they assessed all the competencies they were expected to carry out as part of their role.

● Medicines training and competency assessments for staff administering medicines were not clearly documented. We could not be assured that all staff administering and managing medicines had the appropriate training or were competent to do so. We saw the registered nurse carrying out other staff's medicine competency assessments, had themselves made a number of medicines errors but continued to assess other staff.

● A person's care plan indicated trained staff were to assist them with stoma care. The training records viewed did not include stoma training and therefore we were not assured any staff was suitably trained and competent to carry out this task. A care staff member told us they carried out stoma care and showed new staff how to care for it. Whilst they were shown how to do it, they had not received any training and their competencies were not assessed to ensure they had the skills for the task. We found neither cook had up to date food hygiene training, and one did not have up to date infection control. According to the training records viewed none of the catering staff had completed the food safety training.

● The provider's policy on staff supervision stated they should receive supervision as a "Minimum of four times per year, as well as an annual appraisal meeting." Supervision of staff was not taking place in line with the provider's policy, unless the staff member had underperformed or there were concerns that needed addressing. Without this form of support and without competency assessments the provider was unable to

assure themselves staff were meeting their expectations and adequately supported.
● Staff told us they did not have regular supervision and did not feel supported. A staff member recalled a group supervision where they discussed paperwork. A staff member commented "Supervision, not had one, think I had a six-month appraisal but that has been it," and "Supervision, lack of continuity and inconsistent in the support provided."
● People commented "Some of the agency staff I would change, they tend not to listen and not all of them know what they are doing and some of them tell people off."

Staff were not suitably trained, supported and supervised. This was a breach of regulation 18(2)(a), (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider confirmed in response to the draft inspection report face to face training was impacted by the pandemic, which resulted in staff training and competency assessments not been completed in line with their policy.

● New staff on duty at the inspection told us they had shadowed experienced staff as part of their induction and felt supported in their role. They described the senior carer they worked alongside as a "positive role model."

Supporting people to live healthier lives, access healthcare services and support, Staff working with other agencies to provide consistent, effective, timely care, Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's health needs and changes in them were not responded to in a timely manner. On the afternoon of the second day of the inspection a person told us they were unwell, hot and appeared uneasy. They believed the GP had been informed in the morning. A senior carer informed us the GP had been emailed in the morning, however the GP had not received the email due to poor internet connections at the service. This was not identified until the afternoon and the service then contacted Telemeds for advice. The person was admitted to hospital that evening.
● Medical equipment such as blood glucose and blood pressure monitors were not calibrated. Therefore, we could not be assured that the equipment being used to monitor peoples blood glucose and blood pressure were accurate.
● Systems were in place to record people's bowel movements. However, there was no guidance in place as to the action to take and when if a person did not open their bowels regularly. In one person's bowel chart there was no record over a seven- day period to indicate they had opened their bowels. On the seventh day it was noted they were constipated. This had the potential to cause discomfort and pain for the person as well as complications of bowel impaction.
● A hospital discharge letter on a person's file dated 26 October 2021 raised concerns about a missed hospital appointment in September 2021. The provider was unable to explain why this had occurred.
● There was no clear documentation in care plans about regular reviews with GP's or other healthcare professionals. Health professionals working with the service gave us examples where the service failed to recognise changes in people's health and medical conditions, with staff being reactive as opposed to proactive, which resulted in deterioration in individual's health or a hospital admission.
● A person was anxious they would not get to a forthcoming appointment. They commented "I know I have a dental appointment coming up shortly, but I am worried who might be able to take me, to escort me and whether I will get there."
●People were assessed on admission to the service. The assessment documents were not always routinely fully completed to indicate people's needs and choices had been identified.

Safe care and treatment was not always provided. This was a breach of regulation 12 (1), 12(2)(i), (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● In response to concerns from health professionals working with the home the deputy manager had taken on the clinical lead role. They had introduced a GP communication log to ensure people's healthcare needs were identified and reviewed by health professionals in a timely manner.

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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● Staff were not working to the principles of the MCA 2005. Some MCA's viewed did not include the decision to be made and that section was blank. A person on one to one care had no MCA regarding that decision in place. The DoLS application on file makes no reference to one to one care and this was not updated in response to the introduction of one to one care. They had no MCA's for other aspects of their care either.
● Another person had bed rails in use. They were deemed not to have capacity. No MCA for that decision or other aspects of care was on file. There was one MCA on file which did not include the decision to be made.
● No person had MCA's in place in relation to COVID -19 testing which they had regularly been involved in.

The service was not working to the principles of the MCA. This was a breach of regulation 11(1), Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
● The home was not suitably maintained or fit for purpose. The enclosed garden was a trip hazard and areas of the home had damp patches on the wall, stained ceilings, damaged doors, broken tiles, broken equipment and generally tired and not fit for purpose. Flooring in bathrooms and showers were badly stained and lifting from the wall and in one ensuite shower room the base was coming away from the shower tray. Carpets were worn and armchairs were stained.
● People were not routinely protected from unsafe premises. We noted a toilet seat was not fitted correctly which meant there was a risk of falls for people. A joining strip between two floor surfaces was loose and presented as a trip hazard. This was rectified after we pointed it out to the regional manager. In the bar area, we saw wood used to construct the bar was rough and had not been finished to protect people from the risk of skin tears or splinters.
● The fire door in the downstairs bar area, needed relaxing, as the speed at which it shut had the potential to cause people injury. The maintenance person made the necessary adjustments, but then the door did not shut properly. It was important that the door did close properly as it was a fire door.
● The provider confirmed improvements were planned to the service. They were unable to provide a

breakdown for the work scheduled or a time frame for completion.
● There was a lack of managerial oversight regarding the cleanliness of the building. There were malodorous aromas present in various parts of the service. We found urine on the floor in one bathroom and on a shower chair in another bathroom. The kitchen, laundry room and equipment was greasy, dirty and dusty, with other equipment such as the dishwasher out of use.
● Health and safety checks were not effective in identifying health and safety issues within the service with no action taken in response to the water temperature exceeding the safe temperature. The electrical installation certificate dated 24 April 2019 was unsatisfactory. There was no evidence to suggest the work has been done and a new certificate issued. This and other concerns about fire safety was referred to the Fire Authority to follow up on.

The service was not suitably maintained, clean or fit for purpose. This was a breach of regulation 15 (1)(a),15(1)(c),15(1)(e), 15(2), (Premises and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider confirmed refurbishment of the service had commenced but was stopped as a result of the pandemic, outbreaks of COVID -19 in the service, a backlog of works and a shortage of supplies.

● Checks were completed on areas of the service that posed a risk to people's health and welfare such as fire alarm equipment, and portable appliance testing (PAT). An up to date gas safety certificate was in place and a legionella audit certificate was completed in June 2021.

Supporting people to eat and drink enough to maintain a balanced diet
● People's care plans outlined their nutritional needs and risks. However, staff practice and people's records did not assure us that people's nutritional needs were met. This is because records were incomplete and changes in people's meals were not communicated to the kitchen staff.
● We observed mealtimes over the course of the inspection. On the first floor on both days of the inspection people were not supervised, encouraged or supported with their meals. Therefore, there was no oversight of meals eaten and risks around mealtimes were not mitigated. On both days of the inspection we saw one person did not eat their meal and this was not addressed and acted on. People in their bedrooms who required assistance with meals were not given their meals until an hour after the lunchtime meal had started.
● During the inspection we heard people say their meal was cold and a relative asked staff to reheat their family members meal which was cold. We observed the glass of water people had in their bedrooms was low or empty and no refills were provided. For some people their drink/glass was out of their immediate range and the water dispenser provided to people had no disposable cups available. People were not routinely offered a drink with their meal. This had the potential to limit their access to adequate fluids to promote their hydration.
● We received mixed feedback on the meals provided. A person commented "I have said at several Residents' Meetings, we need fresh fruit." They told us another person loves fruit too and encouraged them to say something. They commented "You have to tell them you want fresh fruit, you have a voice we should tell them". Another person told us they buy their own food and gets the kitchen to cook it for them. They commented "I was sick and tired of casseroles. A pie in this place is a casserole with a pastry lid on and the puddings are stodgy."
● Other people indicated there was little choice but found the food good. They commented, "The food here is good, there is not a choice but I know they would probably knock something up for me if I ask. I get on well with the chef" and "The food is very good, you get what you are given, there is no choice although I do get a choice at breakfast."

It is recommended the provider seeks advice from a reputable source to enable them to consistently meet people's hydration and nutrition needs.

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.

This is the first inspection for this newly registered service. This key question has been rated 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

- Due to lack of staff presence on the floors limited engagement with people was observed. However, the engagement observed was mainly negative. Throughout the inspection we heard staff use terms of endearment such as, ""Hello Love," "Alright darling," and "Lovie" without any consideration if that was how people wished to be addressed.
- Some staff did not engage or smile at people whilst serving meals. A person who was sat alone in their bedroom was provided with assistance to eat their lunch. However, the staff member supporting them failed to engage in conversation with them. Another staff member took a person's unfinished meal and tray away without encouraging them to finish their meal or acknowledge them.
- At lunchtime a person made a member of staff aware they needed to use the toilet. A care worker informed the nurse who shouted across the dining room "Do you want the toilet?".
- A staff member in passing asked a person if they were alright. The person replied "Terrible," the carer said "Why" and continued walking. These practices did not ensure people were well treated and supported.

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

- People were not supported to be involved in decisions about their care. Their care plans showed that they were not actively involved in them or contributed to them.
- At lunchtime we observed people were provided with one drink choice and not asked what pudding they wanted. When we asked why people were not given a choice of pudding, the staff member stated, "I have worked here for four years and I know what people like."

Respecting and promoting people's privacy, dignity and independence

- People's privacy and dignity was not consistently promoted. The lock in one of the toilets was not working and therefore the toilet was not locked when in use. A person told us they could not use their shower as it did not have a screen. Throughout the inspection we observed that few, if any staff knocked on peoples' doors, before entering their bedrooms, despite each bedroom having a door knocker in situ.
- During the inspection a cleaner proceeded to clean a person's bedroom whilst they had a visitor, without considering the impact of that for the person and their family member. Another staff member came into a person's bedroom whilst we were speaking with the person. The staff member did not knock or announce their arrival or speak to the person before they then left.

It is recommended the provider works to best practice to promote people's privacy, dignity, choices and ensure they are treated with respect.

● During the inspection we observed one staff member engaging positively with people. They asked people if they wanted any sauces with their lunch and engaged in meaningful conversation about what they were eating. They were discreet when speaking with people and people responded positively to them.

● People were mainly positive about the permanent staff and described them as "kind, caring and friendly". People commented "The carers look after me and everyone is so kind to me," and "I like the staff, they are friendly. They always have fifty things to do though, they only have one pair of hands, you often hear them saying, I'll be back later."

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated 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

- Person centred care was not provided. Care plans lacked specific information on how people were to be supported. They indicated full support required or assist as required. Individual preferences were not taken into account to promote people's protected characteristics. A person told us they had requested female staff only to support them with personal care, but this was not always provided. A relative told us of an occasion where two male carers were providing care to their family member, which they felt was inappropriate.
- Care plans showed no evidence of people involvement in them and whilst reviewed, the reviews failed to pick up changes in people. One person's care plan indicated they were on a specialist diet and required thickener in their drinks. Their daily observation charts showed this was not provided and had the potential to put the person at risk. However, in response to our feedback to the provider, they confirmed the person had made the decision to not follow the guidance given to them about their food and fluid but the service had failed to update the care plan to reflect the person's decision and plan of care.
- People's medical needs such as diabetes and Parkinson's was identified but no guidance was provided on how that impacted on people or the support required.
- A person commented "I am accepting of what is on offer here, all the basics are very good here. I suppose I am accepting of life here rather than happy. I'm pretty easy going and I tend not to complain."

Person centred care was not provided. This was a breach of regulation 9 (1), 9(2), 9(3)(a),9(3)(b), 9(3)(c), (Person centred care) of the Health and Social Care Act 2008 (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

- People told us the activities provided were limited. A person told us they were surprised by the appearance, for the first time in their experience, of a printed sheet of planned activities which was distributed to them that week. Another person commented "This is a joke, it is only because you are here."
- People commented "I find there is nothing to do, I just do my Word Games, there are no activities taking place as far as I have seen," and " I feel lonely, mainly only have the television to watch."
- The activity programme outlined one to one activities occurred each morning and brain power being the common activity in the afternoon. During the inspection we observed the one to one activity recorded on the activity programme did not take place and instead the activity coordinator and two people completed a cross word. Although there are a few games/puzzles stored in areas of the service, none of these items were in use on the day and no one mentioned that any ad hoc activities like this ever took place.

Person centred activities was not provided. This was a breach of regulation 9(3)(d), (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● People's communication needs were briefly identified but no guidance was provided to staff as to how they could meet people's communication needs when people's verbal communication is limited.
● During the inspection we did not observe staff use visual props to engage with people who displayed dementia symptoms and had difficulty communicating their needs. People were generally left alone in their bedrooms and lounges with limited engagement between people and staff noted.
● Policies and procedures pertaining to people's care was not available in large print /easy read except for the complaints procedure. This impacted their ability to access key information on their care.

People were not enabled to be involved in their care. This was a breach of regulation 9(3)(d),(Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
● The service had a complaints policy in place which indicated complaints would be investigated and a response provided within 21 days. It outlined who the complaint could be escalated too. Complaints were recorded, investigated and responded to in line with the providers policy.
● Whilst people told us they were not aware of the complaints procedure they told us they would talk to one of the permanent staff about their concerns. Relatives told us they were not aware of a formal complaints procedure but would inform staff. Relatives commented "I am not sure what the formal way to make a complaint is but if there is a problem, I would try to speak to someone who is on duty at the time. Generally, I get a response verbally" and "I have never needed to raise a complaint and do not know what the process should be. I would probably firstly contact the manager."

End of life care and support
● People's care plans included a "Do not attempt cardiopulmonary resuscitation (DNACPR)", where this was agreed and decided. End of life care plans were in place as to people's choices in relation to their death.

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.

This is the first inspection for this newly registered service. This key question has been rated 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

●Our findings from the inspection showed the service was not safely managed or appropriately audited to mitigate risks and meet regulatory requirements. The provider had systems in place to monitor the service which included daily, weekly, monthly, quarterly and an annual audit by the provider. However, the audits were not effective in picking up the issues we found.

● The provider failed to effectively audit the repairs and cleanliness of the service. Infection control audit completed on 25 February 2022 showed a total score of 91% and the catering audit completed on the 25 February 2022 showed a total score of 94%. However, on our inspection three days later we found the home was unhygienic with poor standards of cleanliness throughout, including concerns with food storage, undated food in freezer, freezer frosted over, and unsuitable containers being used for food storage, including in a hot food trolley. Where actions were required as a result of audits there was no overview of those to ensure actions were completed. Care plan and medicine audits had not identified the shortfalls we found in those records to ensure risks were mitigated and actions from those audits were not completed.

● People's care records were not always contemporaneous, accurate, complete or secure. During the inspection we observed the nurse's office doors were unlocked when unattended. Therefore, confidential records were accessible to people. People's fluid charts were incomplete and total fluid intake and output was not recorded. A person's daily record had no entry between the 17 February and 26 February 2022. Personal care records, daily records, bowel monitoring and repositioning charts showed gaps in recording and records including accident reports were not consistently reviewed and signed off. Where they were, they did not address shortfalls in the records and measures were not put in place to mitigate risks.

● Other records such as training, supervision, inductions and rotas were not audited and the provider had not identified gaps in those records, including not assuring themselves that staff were suitably trained and there was sufficient staff on duty. The staff list provided, rota and training records were contradictory as to the staff currently employed, which meant there was no overview of those records to ensure they were accurate.

● Staff were not suitably skilled and trained for their roles and responsibilities delegated to them such as auditing, pressure area care, stoma care, catheter care, fire and health and safety checks. There was contradiction between the providers fire risk assessment, fire evacuation and fire policy as to who was responsible for specific roles in relation to fire safety. As a result, the maintenance staff member was carrying out tasks they were not trained in and was not in line with the providers policy. This practice increased risks to people.

● Personal Emergency Evacuation Plans (PEEP's) were maintained on people's files with a copy included in

the emergency grab pack. The PEEP's records in the emergency grab pack were not reflective of people currently in the service and therefore an accurate record was not accessible in the event of a fire. The emergency evacuation bag checklist, states content to be checked weekly. The records showed it was checked four times since January 2021.

Good governance was not established, and records were not suitably maintained. This was a breach of regulation 17 (1),17(2)(a), 17(2)b), 17(2)(c), 17(2)(d), (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

● The service had no registered manager since October 2021. Whilst another manager had been appointed, they had not become registered with the Commission and left the service in January 2022. At the time of the inspection an interim manager had been appointed and was due to start on 16 March 2022.

● Staff did not feel the service was well managed. They commented "There is no leadership and we get mixed messages from senior managers", "Things get changed but not sure the change is beneficial", "The lack of stability of a manager gives lack of certainty" and " There are too many management changes, we are winging it with no consequence for anything."

The service was not suitably managed to achieve good outcomes for people. This was a breach of regulation 17(1), (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider confirmed in response to the draft inspection report that whilst they acknowledge there was inconsistencies in management, the provider did ensure the service did have management cover.

● Staff told us the deputy manager was friendly, accessible, approachable and listens. Staff commented "I think [deputy managers name] is good for this place, they are the first one that has come in and put the people living here first and also looks after the staff."

● People spoke positively about the deputy manager. They commented "[Deputy managers name] has been the Deputy Manager since December. She does some nursing too. The atmosphere is so much better since she came here." A relative commented [Deputy managers name] is fantastic, Mum trusts her and she really means it."

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

● Systems were not effective in engaging and involving people, relatives and stakeholders. The provider confirmed surveys were yearly, however people, relatives and stakeholders were not given the opportunity to provide feedback on the service since the provider had taken over the service in May 2020. Resident and staff meeting meetings were not carried out at the frequency determined by the provider with the last resident meeting recorded as taking place on 11 June 2021 and the last staff meeting took place in November 2021. Staff felt communication was improving but they were not aware a turnaround manager was due to start working at the service.

● People and their relatives did not recall being asked to give feedback on the service. At the start of the pandemic communication with relatives was described as "generally good," but more recently relatives described communication as "non-existent."

● People and their relatives felt engagement with them was poor. They were not aware a new manager had been appointed. A relative commented "Communications here have not been good at all, relatives and residents rarely get notified of information like that. New appointments should be announced."

Systems were not established to seek and act on feedback to continually evaluate and improve the service. This was a breach of regulation 17(2)(e), (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care Working in partnership with others
●Systems were not effective to promote learning from incidents and improvements were not embedded into practice to improve care.
●There was no oversight of staff to assess skills, competencies and promote continuous learning to improve care.
● Health professionals worked closely with the service, although partnership working was not established to promote positive outcomes for people.
● Community links were not established to benefit people and people described the service as "working in isolation." The provider confirmed in response to the draft report that the community links were restricted due to the pandemic and the service being in lockdown.

Continuous learning was not established to improve care. This was a breach of regulation 17(2)(f), (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider is required to inform us of incidents such as an injury to a person. From the records viewed, we saw the required notifications were not made. These related to an accident where the person was injured and admitted to hospital and a safeguarding incident where a person was injured during a moving and handling manoeuvre.

The required notifications were not made to the Commission. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider had a duty of candour policy in place. However, we found a letter of apology was not routinely sent to people or their relative at the time of the incident. This was actioned in retrospect, when we pointed it out to the service.

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
Treatment of disease, disorder or injury	The required notifications were not made to the Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	Person centred care was not provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The service did not work to the principles of the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment
Treatment of disease, disorder or injury	The service was not suitably maintained and hygienic.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Safe care and treatment was not provided.

The enforcement action we took:

We served a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Good governance was not established to ensure the service was suitably managed and monitored.

The enforcement action we took:

We served a warning notice.

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 Sufficient numbers of suitably trained staff were not provided.

The enforcement action we took:

We served a warning notice.