Barleycroft Care Home Ltd

# Barleycroft Care Home

## Inspection report

Spring Gardens
Romford
RM7 9LD

Tel: 01708753476

Date of inspection visit:
09 February 2021
16 February 2021

Date of publication:
02 June 2021

## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

| | |
|---|---|
| Is the service safe? | **Inadequate** |
| Is the service effective? | **Requires Improvement** |
| 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
Barleycroft is a care home that provides accommodation, personal and nursing care for up to 80 people across three separate floors, each of which has separate adapted facilities. One of the floors specialises in providing care to people living with dementia. At the time of the inspection there were 71 people using the service.

People's experience of using this service and what we found
Risks associated with people's care and support had not been fully assessed. There was no detailed guidance in place in certain areas of people's care for staff to follow, to keep people safe. People's medicines were not always managed safely because we found shortfalls around the provider's arrangements to make sure people received their medicines safely and as prescribed.

We noted that care records did not always contain information relevant to the person and were not individualised to reflect people's needs and preferences. People's end of life wishes were not always identified and recorded. The needs of people were not always assessed before they used the service. The registered manager had not maintained securely an accurate, complete and contemporaneous record in respect of the care and treatment delivered to people who used the service.

Accidents and incidents were recorded but not monitored to identify how the risks of reoccurrence could be minimised in future. Staff competency was not being effectively monitored to make sure people received safe care. The management team did not have a system to check if staff were supporting people safely. Staff received training but it did not cover all areas of people's support needs. There were quality assurance and governance systems in place to drive continuous improvement; however, the systems were not always working effectively because the provider had not identified and improved the issues we found during the inspection.

Infection control procedures had been enhanced due to the risk of COVID-19 and we observed the service was clean and a cleaning schedule was in place. Personal protective equipment (PPE) was readily available and people and staff were tested regularly to help prevent the spread of infection. There were sufficient staff working for the service and safe recruitment procedures were followed. People were encouraged to be independent. There was a complaints policy and procedure in place which people and their relatives had access to. The management team had good links with the wider community and worked in partnership with other agencies to help ensure a joined-up approach to people's support.

People supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Rating at last inspection

The last rating for the service under the previous provider (Festival Care Homes Ltd) was good, published on 7 June 2019. This service was registered with us under the current provider on 17/12/2019 and this is its first inspection.

Why we inspected
The inspection was prompted in part by notification of a specific incident following which a person using the service sadly died. This occurred in June 2019, under the management of the previous provider. The incident was subject to a criminal investigation which concluded in June 2020, with no action taken. However, the inspection did look at risks to people using the service, and specifically the management of head injuries, which the incident was related to.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, responsive, caring 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.

We also looked at infection prevention and control measures. 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 coronavirus and other infection outbreaks effectively. Please look at the safe question of this part of the report.

Enforcement:
We have identified breaches of regulations in relation to safe care and treatment, person centred care, staff training, safety of the premises and quality assurance at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
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?**<br>The service was not safe.<br>Details are in our safe findings below. | **Inadequate** |
| **Is the service effective?**<br>The service was not always effective.<br>Details are in our effective findings below. | **Requires Improvement** |
| **Is the service caring?**<br>The service was not always caring.<br>Details are in our caring findings below. | **Requires Improvement** |
| **Is the service responsive?**<br>The service was not always responsive.<br>Details are in our responsive findings below. | **Requires Improvement** |
| **Is the service well-led?**<br>The service was not well-led.<br>Details are in our well-led findings below. | **Inadequate** |

# Barleycroft 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 Care Act 2014.

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

Inspection team
The inspection was carried out by three inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

The service had a manager registered with the Care Quality Commission. 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.

Notice of inspection
We gave a short period of notice on the day of the inspection. This was because we wanted to get an update about the incidence of COVID-19 infection in the home.

What we did before the inspection
We reviewed the information we held about the registered provider, including previous notifications. A notification is information about important events, which the registered provider is required to send to us by law. The provider was not asked to complete a provider information return prior to this inspection. This is

information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We reviewed a range of records. This included 17 people's care plans, risk assessments and 10 medicine administration records. This also included staff files, catering audits, Deprivation of Liberty Safeguards authorisations records and compliments and complaints records. We spoke with the registered manager, deputy manager, office manager, one nurse, the chef and the activity coordinator.

After the inspection
We continued to seek clarification from the provider to validate evidence found such as policies and actions plans. We spoke with six people who used the service, ten relatives of people who used the service and five staff members by telephone.

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 for this newly registered service. This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

● People told us staff assisted them to take their medicines as prescribed and they were happy with the arrangements. One person said, "Yeah, I take meds, and they [staff] are there when they are meant to be."

● Notwithstanding the above, our findings show that people did not always receive their medicines when needed. Staff completed electronic medicines administration records (MARs) when medicines were given or not given. However, we saw that one person had not taken their regular medicines on multiple occasions and staff had not contacted the GP for advice. These medicines included eye drops and glaucoma medicines but also a medicine prescribed for a heart condition. This meant there was a risk that the person would not receive the intended health outcomes from their medicines which put them at risk of harm. We raised this with the registered manager. They also reported it to their local safeguarding team and sent a notification to the CQC.

● We found the provider had recently updated its medicines policy. However, this was not always followed. For example, the medicine refrigerator temperature records did not include the maximum temperatures it reached. This was not in line with the providers own policy and had not been identified on the medicines audit. This meant that the provider could not be assured that medicines were stored within the recommended range of 2-8 degree Celsius and that they would be effective.

● Some people's care plans, did not always include information about the medicines used to manage their health conditions or how to monitor people to minimise risks. One person was prescribed a medicine for treatment of epilepsy seizures. However, the use of these did not feature in their epilepsy care plan. Another person was prescribed medicines for end of life care. These medicines were not listed in their care plan. Body maps were in place alongside topical MAR charts, for medicines such as creams but were not used to indicate where on the body creams should be applied. This meant staff would not always know about medicines used to treat certain conditions.

● There was no clear guidance for staff on protocols they should follow for PRN (when required) medicines where a variable dose was prescribed. For example, one PRN medicine was prescribed to be taken one to two times at night, but the protocols said the maximum dose in 24 hours was four tablets. The dosage for one person's injection was prescribed as 2.5mg – 5mg; the protocol did not state in what circumstances 2.5mg or 5 mg should be given, or how long to wait to give a further 2.5mg after an initial 2.5mg dose.

We found that the provider did not have robust systems to protect people from the risks associated with the management of medicines. This was a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Assessing risk, safety monitoring and management

● We noted some people did not have comprehensive risk assessments in place. For example, some people were prescribed medicines where they could bleed or bruise easily if they had a fall. This risk had not been

assessed and there was no guidance for staff to manage these risks appropriately. Therefore, people were at risk of receiving unsafe care and support, as staff did not have appropriate guidance to follow to reduce risks for people.

● In November 2020, one person's incident records showed that they had a fall and had sustained a large lump on the back of their head. Although an ambulance was called and their vital signs were checked, there was no record to evidence that neurological observations were carried out, as part of the procedure staff needed to follow for head injuries. This meant that the person was placed at risk of harm as appropriate checks and actions had not been completed to ensure they were safe.

● During the inspection, we noted two people at times behaved in a way that could challenge staff and the service. Although risk assessments were in place that included potential behaviour triggers, the risk assessments lacked detail on de-escalation techniques staff may use to support the person. We found incident records had been kept of when both people demonstrated behaviours that may challenge. However, these were not analysed to identify trends and patterns that could then be used to plan effective strategies to minimise risks when people would behave in a way that challenged others. The failure to accurately assess and include measures to minimise risks in these areas placed the two people at risk of harm to themselves and to other people using the service and staff.

We found that systems were not always in place to effectively assess and managed risks to people while they receive a service.

This was a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The provider had a system to maintain and service equipment at the service. We saw fire extinguishers had been serviced in December 2020 and portable appliances testing had been done. However, we found that although there was a due date for an electrical wiring test visit to be carried out in October 2021, there was no actual report from the last electrical wiring test to check when it was carried out and to check whether any identified remedial work had been completed. Following the inspection, the provider sent us evidence of a valid electrical wiring test certificate dated October 2016. The service also had an expired gas certificate for the cooker. This was brought to the attention of the registered manager.

● We found on the second floor there was a fire sledge to evacuate people in the event of emergencies. The first floor did not have one in place. The provider purchased a fire sledge for the first floor following our visit.

Learning lessons when things go wrong

● The provider had systems in place for recording of incidents or accidents. However, there was no process prior to January 2021 for how the provider learnt from lessons following incidents or accidents to improve quality of care to people.

● Our evidence showed that there had not been learning from previous accidents and incidents, including a serious incident that occurred in June 2019 under the previous provider. The provider had also not implemented systems to review and learn from accidents and incidents until more recently in January 2021. During the inspection the registered manager told us that they had just started analysing the incidents and accidents from January 2021 to reduce the likelihood of them happening again.

Systems and processes to safeguard people from the risk of abuse

● People told us they had no concerns and felt safe at the service. One person said, "I feel as safe as anyone could be." Another person told us, "I do feel safe, they are very good". The provider had procedures in place to safeguard people from harm. Staff had received training in the subject.

● Information was made available on who to contact if people wanted to raise any concerns. However, we

noted that the local safeguarding team and our contact details were missing on the provider's policies and procedures on safeguarding adults. This meant people, staff or relatives might not know how to contact relevant statutory agencies including the local authority or the CQC if they wished to. The safeguarding policy was due to be updated in December 2020, but this did not happen.

● One member of staff told us, "I will report any abuse to the manager." Another member of staff told us of the actions they would take if they felt somebody was being abused. Staff were also aware of the whistleblowing procedures. A whistle blower is a person who exposes any kind of information or activity that is deemed illegal, unethical, or not correct within an organisation.

Staffing and recruitment

● People and their relatives felt there were enough staff working at the service. One person told us, "They [staff] are there for you if you need them, you just press a buzzer. They come as quick as they can, a couple of minutes. Staff work hard, there is enough to cope with the day to day. There is always someone on the floor if you want". One relative told us, "When I have visited there seems to be a fair amount of staff around."

● People received care and support from staff who worked regularly at the service. This helped with consistency of care and support people were provided with.

● People were protected from the risk of receiving care from unsuitable staff. The provider carried out all relevant checks before new staff began at the service. The checks included written references, proof of identity, confirmation of previous training and qualifications and checking if staff had any criminal records.

Preventing and controlling infection

● There were policies and procedures regarding the prevention and control of infection. Staff had received training and were aware of their responsibilities in this area. Personal protective equipment (PPE) such as gloves and aprons were provided to staff and this helped to minimise the spread of infection.

● One person told us, "To be honest I have felt safe during COVID, they follow the rules, we follow the rules". Another person said, "Staff always have masks on, nurses also wear plastic aprons". Staff had received infection control training.

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

● We were somewhat assured that the provider was meeting shielding and social distancing rules. There was no zoning in place currently. We signposted the provider to the guidance on zoning and traffic light system.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● 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.

Requires Improvement

# 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 requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- People's needs were not appropriately assessed before they were admitted to the service. The provider did not have robust assessments in place to ensure that the service could meet the needs of people prior to offering to care for them at their service. This meant people were at risk of receiving care from staff who did not fully understand their health conditions or preferences in how care was delivered.
- This issue was discussed with the registered manager who stated they would discuss any referrals that they had received from the referring agencies for admission with the nurses. They would then decide whether the person can be admitted. We asked how this was recorded and the registered manager could not give us an answer. There was a pre-admission assessment template on the provider's digital system, but this was not completed in most of the care plans we looked at.
- In two cases where we had previously asked for the preadmission assessments of specific people, the provider was unable to locate and send them to us. They informed us the assessments had been archived but were unable to find them.
- There was a risk that people's needs were not being assessed correctly in line with legislation. The above shows that the provider had not always carried out, collaboratively, with the relevant person an assessment of people's needs and preferences, to confirm they would be able to provider person-centred care to them according to their needs and preferences.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- Staff did not always have the right training, skills or experience to support people effectively. Where there was a need to provide training to staff to ensure they were skilled and competent to care for people safely, this has not always been provided promptly. Following a previous incident there had been a delay in training staff in areas where improvements were required such as on how to support people who had suffered a head injury or required blood thinning medicine. The registered manager informed us that staff had received training in blood thinning in September 2019 but training on head injuries was booked for March 2021.
- The provider did not always support staff to ensure they had the necessary training or understanding to support people with complex needs. This meant that people were at risk of receiving unsafe care.

This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

● There was a system in place to monitor which training staff had attended and when they were due for refresher training. We saw emails had been sent out by the management team to staff reminding them of the importance of keeping up to date with their training. The provider had now put a system in place to check on staff competency following training to ensure they had the skills to support people safely.
● When staff started working for the service, they were provided with an induction programme. All staff files we looked at contained induction paperwork which indicated staff had been orientated into the service. Induction included health and safety, shadowing, competencies and observations with sign off from management.
● Staff were also given an opportunity to discuss any work-related issues, with their line managers. The provider had a supervision policy. The policy stated staff would receive "appropriate ongoing or periodic supervision in their role to make sure they are competent to undertake their role and responsibilities." The service maintained a supervision matrix to record when staff had received supervision.
● Staff supervision from management was recorded. General topics and themes, such as infection control and responding to call bells, were discussed with staff who signed notes to state these had been discussed.

Adapting service, design, decoration to meet people's needs
● The service contained various adaptations to support meeting people's mobility needs such as handrails and lifts. The provider had planned to enhance the area further to include sensory and tactile boards and items. This was put on hold in keeping with government recommendations to limit and minimise touch points and surfaces due to the Covid 19 pandemic.
●The provider informed us they had received funding for a sensory room and were able to show us themed wallpaper they hoped to put up.
● People were encouraged to decorate their own rooms. We saw rooms had been personalised and contained photos and furniture belonging to people. People's rooms had photographs on their doors and bathroom doors and doorways were distinctively decorated.

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to eat and drink to maintain their health and nutrition. We observed people having lunch and saw, people were assisted to eat and drink where required.
● People told us that staff supported them with their food and drinks. One person said, "Food is fine, you get a choice and there is usually something I want". Another person told us, "Food is good, I like Indian food and I get that". A relative commented, "The food is very good and as a visitor you could order a meal when you visited."
● Care plans recorded people's dietary needs and preferences. This information was shared with kitchen staff, so they knew whether people had allergies or religious restrictions with food. There were records of interaction with healthcare professionals regarding food and fluids, directing how staff could best support people in this regard. Menu and food choices were discussed at resident meetings. This meant people were supported to eat and drink enough and to maintain a balanced diet.

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

and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● The service tracked whether people required DoLS authorisations and what stage their DoLS applications and authorisations were at. However, we reviewed the provider's DoLS tracker and noted not everyone's information had been recorded correctly. We were unable to tell from the tracker whether some people should have DoLS authorisation in place or not and or whether these had been applied for or authorised.
● The registered manager told us this was an administrative oversight and would update the DoLS tracker with all the necessary information.
● Care plans contained documentation that supported people making their own choices and decisions where possible. Numerous care plans for people with dementia indicated people's desire to remain independent and how they could be supported to make choices. For example, one care plan highlighted how staff should use the pictorial menu to assist a person choosing their meal.
● Care plans also recorded where people and or their relatives (where they were legally authorised) had consented to their care. On top of this the service also had arrangements around gaining consent to use and store their information and whether the service could take photos of them.

Staff working with other agencies to provide consistent, effective, timely care. Supporting people to live healthier lives, access healthcare services and support
● The registered manager worked closely with other health professionals to ensure people were supported with their healthcare needs. Where people required it, the registered manager sought healthcare advice and support for them from external professionals such as GP's. One person told us, "I see my doctor, but not everyday". Another said, "They [staff] arrange all that, if you need to see a doctor, everything is there for you".
● People's ongoing progress and needs were communicated effectively. Staff recorded updates about people's welfare in electronic progress notes that could be accessed by all staff logged into the service's electronic care plan system. Observations of people and updates were written into these progress notes and if required, actions and alerts could be tagged on the care planning system
● Interaction with health care professionals was recorded in care plans to assist staff to support people appropriately. Healthcare professionals, such as GPs, chiropodists and dieticians were all engaged in supporting people to have their health needs met by the service.

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.

Respecting and promoting people's privacy, dignity and independence

● We received mixed feedback about how staff supported people with privacy and dignity. One person said, "It's very good, staff are very helpful, they do anything I need them to do. When they clean me, they do it very nicely, very carefully". Another person told us, "Staff are good, I can do what I need to do, and they put creams on my feet". A third person told us, "Staff do nothing, they just ignore you".

● A relative said, "They [staff] seem caring, it comes across. It's the little things though, like apples that are going off are not chucked away. Their [person] nails are getting long and are grubby. I really don't know anymore." Another relative told us, "I can't say the staff are overfriendly, but that's probably due to masks and Covid." A third relative said, "When you are there, [person] is always clean and tidy. On occasions they had not shaved, and I'd only have to mention it to somebody, and they would do it straight away. There is a staff member who is cutting their hair and doing a good job of it."

● The provider had not always shown respect to people using the service because they had not always ensured people receive a quality service and they had not done all that was reasonably practicable to help protect them from the risk of harm. Despite some areas having been identified as risky areas the provider did not take timely action to minimise the risks and to demonstrate they cared about people and were doing all that was possible to help protect them.

● Staff told us how they would maintain a person's privacy and dignity when assisting them with personal care. This included closing doors and seeking the person's permission first before doing anything. One member of staff said, "I make sure the door is closed when giving personal care."

● Staff encouraged people to maintain their independence. They knew how much each person was able to do for themselves and what assistance they needed. One member of staff said, "[Person] is able to wash their face and top half, I help them where they help with."

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

● People told us that they were given a choice. One person said, "Staff are good, yes I am always able to get someone. I have lots of choices."

● However, we noted that care plans did not always contain information relevant to the person and were not individualised to reflect people's needs. People's end of life wishes were not always recorded. Therefore, the provider did not promote a positive person-centred culture which took account of people' views and preferences and promoted good outcomes for them.

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

● During our visit we saw staff interacted with people in a kind way, but we did not always see staff engage

and take time to chat with them. One person said, "I get on with all of them. I keep out of trouble". Another told us, "Staff are good, I can do what I need to do, and they put creams on my feet."

● The staff promoted the equality and diversity of people who used the service. They ensured people had equal opportunities, regardless of their abilities, their background or their lifestyle. For example, people had equal access to food they like, taking into account their individual circumstances. One member of staff said, "We treat the residents according to their wishes."

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; End of life care and support

- People's care was not always personalised. Care records did not capture people's needs and the action to take to meet identified needs. This meant that staff reading the care records would not have the guidance or instructions to provide care to people which was person- centred.
- For example, one person was prescribed a medicine that help to prevent seizures. This information was not recorded in their care plan. Another person was prescribed medicines for end of life and again this information was missing in their care plan. This meant care records did not contain sufficient information about the care and support people needed. People could be at risk of not receiving appropriate in an emergency.
- We noted where people had behaviours that could challenge the service, they did not have individualised care plans to reflect their individual needs and circumstances and the action to take to care and support them accordingly.
- People's end of life wishes were not always recorded. We looked at eight people's end of life care plans and wishes. We found only two plans where people's wishes for the future were recorded.
- We asked the management at the service about this and they told us people and their relatives often did not want to have these types of difficult discussions. However, the service was not recording where people did not want to have discussions about their end of life and it was not clear where people have had these discussions and where they had not. Therefore, staff might not have the necessary information to care for people in a person centred way should develop end of life care needs.

The service was not providing personalised care to people. This is a breach of Regulation 9 (person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- People's care plans indicated whether the person had a Do Not Attempt Resuscitation (DNAR) form in place. This is where people and their relatives had consented to being resuscitated, should the person's heart stop beating, or they stopped breathing. Records showed they were consulted by their GP to agree this.

Improving care quality in response to complaints or concerns

- The service had a complaints policy and procedure. The registered manager informed us the service received few complaints but shared the most recent complaint with us. We saw they had responded appropriately to people's concerns. One person told us, "If I had a problem without a doubt, I would go to one of the staff and ask to see the manager." A relative said, "I know about the complaints procedure."
- We requested an analysis of complaints and were informed there was no analysis, though there was some

monitoring of their regularity which was shared with the provider and the local authority. The registered manager told us there was no need for analysis given their irregular occurrence.

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 supported to take part in activities, though staff admitted this had been curtailed somewhat due to a recent COVID-19 outbreak and lockdown restrictions. There was an activities coordinator who ensured people were supported to take part in activities should they wish to.

● Weekly activities were advertised on message boards on different floors and these indicated what activities were being completed on different days. Our inspection took place on Shrove Tuesday, commonly referred to as pancake day. The activities coordinator arranged for people to flip pancakes followed by the opportunity to eat some. We observed people were smiling and laughing when taking part in this activity. Other activities we saw advertised were movies, one-to-one meetings with residents, hand massages and arts and crafts. We also saw photos of people involved in activities in the garden.

● People taking part in activities, either in groups, or in one-to-one meetings with staff were recorded in their care plans. We spoke with the activities coordinator about how they ensured everyone had the opportunity to take part in activities and they told us they usually made visits to people in their rooms or met with them in communal areas.

● We noted at least one person's care plan indicated they had not taken part in any activities for six weeks. The activities coordinator told us their care plan system was currently unable to monitor who was not participating in activities but following our inspection this was something they would look into.

● Relatives were able to visit their loved ones whenever possible. A relative told us, "Before lockdown I could just walk in, there was never any pressure to leave". Another relative said, "I was impressed that they made facilities for us to visit".

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 communication needs were recorded in their care plans. People's communication needs were assessed, so staff knew how people were likely to present and how they might communicate. For example, one care plan we read highlighted how a person found it hard to form words and had stuttered speech. The plan indicated the gestures the person used to communicate. This meant staff knew how best to work with people and understood their communication.

● The service used pictorial menus to assist people with communication needs to choose food they wanted to eat. This meant the service sought to support people with communication needs to make choices about things they wanted to do.

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.

Continuous learning and improving care

● The provider's quality assurance systems and checks were not always robust. There was a lack of systems in place to analyse events, accidents and incidents and complaints to identify what went wrong so action could be taken to help rectify things to prevent similar issues from reoccurring. There was therefore little assurance that any such events or incidents and accidents that had happened previously, would not happen again. We found that analysis of accidents and incidents had only been introduced in January 2021.

● Lessons had not been learnt after a serious incident that happened in June 2019. The provider did not ensure that people's physical conditions and wellbeing were being adequately monitored when they sustained accidents and incidents such as a head injury despite having a policy in place on the management of head injuries. There were also no proper clinical observations including neurological observations when a more recent incident had occurred and a person had sustained a head injury. Throughout this time we noted that staff had yet to receive any training on the management of people with potential head injuries.

● The provider had not followed their own procedures and had not always ensured that prior to people's admission to the service their needs were comprehensively assessed to ensure that the service would be able to meet the needs of the individual according to their choices and preferences.

● We also found the registered person had not always ensured that an accurate, complete and contemporaneous record was maintained in respect of each service user. They had not ensured that each individual using the service had a complete set of records to address risks they faced and the care they needed. Daily records of care were not maintained clearly to state the care people received and how each individual's needs were being met.

● The provider's audits and checks around the management of medicines were lacking. These had not identified the shortfalls regarding medicines management that we identified as part of our inspection. Where shortfalls had been identified, we found that in some cases no action had been taken to address the shortfalls. For example, where a person had refused to take their medicines, there was little evidence of any follow-up action.

The above evidence shows that the provider did not have effective systems to assess, monitor and improve the quality and safety of the service This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● We also received feedback from some relatives that communication was not so good when they tried to

contact the home. Four relatives told us communication was not so good. One relative told us they could not get in contact with their family member over the weekend and the phone is not always answered. Following the inspection, we spoke with the regional director who said there was a fault with the phone system and this had now been resolved.

● Notwithstanding the above most people, staff, relatives commented positively about the registered manager and said they were happy with the way the service was run. One person told us, "[Registered Manager] is a nice manager, they will have a laugh with us. It's very well run". A relative said, "I know them [manager], but not their name."

● Staff told us they were supported by the manager. One member of staff told us, "The manager is very supportive." Another said, "I can talk to the manager if I have anything to discuss and they would always listen."

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

● Staff were clear about their roles and responsibilities and who they were accountable to. They had access to policies and procedures for the service to guide them in their roles. However, we were informed it was only recently that the provider introduced a system to check if staff were familiar with their policies and procedures and were adhering to them.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The registered manager was aware of when the CQC should be made aware of events and the responsibilities of being a registered manager. They have reported events and accidents and incidents to the CQC when these had occurred and as required by law.

● During our inspection, we found at times some records we requested were not easily accessible. Other records we had previously requested from the service had also not been provided and we had been informed these had been archived and they could not be found. Record keeping plays a fundamental part in providing high quality health care. For example, not recording the administration of a medicine to a person on a medicine administration record could lead to the medicine being given again and overdosing the person.

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

● The registered manager had contact with staff and people where they could discuss any issues. They also contacted the relatives to update them on the care needs of their loved ones. However, some relatives told us this is an area that the registered manager and staff could improve on.

● There were regular staff meetings where staff were able to share their views and any concerns they might have. Staff told us they were encouraged to share ideas during these meetings, and they felt listen to by the registered manager.

● There were also regular meetings held with people who use the service too. Records showed people were given opportunities to discuss different areas such as the quality of food being service at these meetings.

Working in partnership with others

● The management team had a good working relationship with other health and social care professionals. Records showed people had been referred to other health services such as GPs when needed. This helped to ensure people's changing needs were being met.

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<br><br>Treatment of disease, disorder or injury | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>The provider had failed to ensure people received person-centred care that met their needs.<br><br>Regulation 9 (1)(a) (b) (c) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The provider did not always support staff to ensure they had the necessary training or understanding to support people with complex needs.<br><br>Regulation 18 (1) (2) (a) (b) |

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 12 HSCA RA Regulations 2014 Safe care and treatment |
| Treatment of disease, disorder or injury | The provider had failed provide care and treatment in a safe way<br>Regulation 12 (1) |

**The enforcement action we took:**

We issued a Warning Notice

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance |
| Treatment of disease, disorder or injury | The provider had failed to operate effective systems and processes to make sure they assess and monitor their service.<br><br>Regulation 17 (1) |

**The enforcement action we took:**

We issued a Warning Notice