Barchester Healthcare Homes Limited

Alice Grange

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Alice Grange is a purpose-built home over three floors, that provides accommodation for older people, some of whom may have nursing needs or be living with dementia. The home can accommodate up to 80 people. On the day of our inspection visit there were 69 people living at the home. The home cares for people who are living with dementia primarily on one floor, referred to as Memory Lane.

People's experience of using this service and what we found
There were not always enough staff effectively deployed to meet people's needs in a timely way. There was a staffing tool in place which the provider used to calculate the number of staff required however there was a discrepancy between the outcomes described by the tool and people's and staffs' lived experience. Recruitment practices were not robust.

Across the home we saw staff were under pressure to meet people's needs and although it was evident, they were trying very hard, we saw instances of shortfalls. For example, people's preferences of when to get up were not being met and a high number of people were being left in bed when this was not their wish. This affected the quality of the service people received in all our key questions.

People were left at risk of poor nutrition and hydration support and at significant risk of developing pressure ulcers due to staff not having sufficient time to provide care for people in the way they needed. Care plans did not accurately reflect people's needs and any risks or how these were mitigated against.

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 home did not support this practice. People's needs were not always assessed adequately. Although people spoke positively about the staff that supported them, it was found staff were not supported adequately.

The home was not well managed, and the provider lacked oversight of quality standards and the care that was being delivered. Audits were not effective and had not identified the issues found during the inspection.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of Care Quality Commission (Registration) Regulations 2009.

Following our inspection the provider took immediate action to address some of the concerns identified. These included taking a voluntary suspension on admitting any further people in to the home and increasing the staffing numbers.

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

Rating at last inspection and update
The last rating for this service was Requires Improvement (published 21 October 2019). At that inspection we

also found three breaches of the regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of the same regulations plus an additional further two regulations.

Why we inspected
The inspection was prompted in part by notification of a specific incident to CQC. Following which a person using the service died. This incident is currently subject to further police investigation. As a result, this inspection did not examine the circumstances of the incident. Prior to the inspection, we also received concerning information that people were not receiving safe care and treatment. Please see the safe, effective, caring, responsive and well-led sections of this full report.

Enforcement
We have identified breaches in relation to safe care and treatment including medicines management, management of risk, staffing, person centred care and how the service is managed at this inspection. Please see the action we have told the provider to take at the end of this report.

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

Follow up
We will 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 always effective.

Details are in our effective findings below.

Inadequate

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not responsive.

Details are in our responsive findings below.

Inadequate

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate

Alice Grange

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.

Inspection team
On the first day, this inspection was undertaken by two 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. On the second day the inspection team consisted of two inspectors and a specialist advisor who was a nurse with a background in general nursing and dementia care.

Service and service type
Alice Grange 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.

There was no manager registered with the Care Quality Commission at the time of our inspection visit. The previous registered manager had left the service in September 2019 however following that another manager was employed who applied for CQC registration but did not remain employed. When in post, a registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. During our inspection visit the provider was represented by an operations manager who was managing the service for the foreseeable future and the deputy manager.

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 also obtained information from

Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with 21 people who used the service and 12 relatives about their experience of the care provided. We spoke with 20 members of staff including; seven care staff, a housekeeper, three nurses, an activities co-ordinator, the manager, the deputy manager, customer relationship manager, the deputy director dementia specialist, acting regional director, regional clinical nurse, kitchen staff and the managing director of the provider company. We spoke with two visiting healthcare professionals. We reviewed 16 people's care files and multiple daily records of care and medication records. We also reviewed three staff personnel files and viewed agency staff profiles. We also looked at a sample of the service's quality assurance systems, the provider's arrangements for managing medication, staff training and supervision records, complaint and compliment records.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We received additional information and feedback from professionals who work in the local authority safeguarding team who are familiar with the service.

Inadequate

Is the service safe?

Our findings

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

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

At our last inspection we were not confident that risks to people had been properly assessed or managed. We also found medicines were not managed in a safe way and we could not be confident people would receive their medicine safely. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvement had not been made at this inspection and the provider was still in breach of Regulation 12.

Assessing risk, safety monitoring and management

- We were not assured that risks to the health, safety and well-being of people were suitably assessed or appropriately monitored within the home. This was because the care records we looked at either lacked clear detail or contained conflicting information.
- People at risk of choking were not always kept safe. The provider had failed to adequately assess and mitigate against the risks of harm to people. One person had experienced a choking episode, but their risk assessment continued to state they were at low risk of this occurring. Their nutrition plan did not refer to a risk of them choking. We found at the back of their care plan a SALT (Speech and Language Therapy) letter on file stating 'due to choking risks' they should be provided with 'modified food and fluids'; however, this information has not been included as part of the persons plan of care.
- We were also concerned about several people's nutritional care and weight loss. Records did not evidence that people were being supported to gain and maintain weight where this was necessary.
- Some people either already had or were at risk of developing a pressure ulcer. Their care plan stated they should be repositioned at specified times during the day and at night to help reduce the risk of further skin damage and to promote healing. This guidance was not being followed by staff.
- Well-being charts were located in people's rooms. For one person it was recorded as part of their care that they were to receive an hourly welfare check and to be re-positioned every two hours due to having three pressure ulcers. We found records did not evidence this level of care was taking place. This placed the person at risk of further skin breakdown and was not in line with professional guidance.
- Records relating to people' s safety were not always up to date or accurate. This meant that staff were unable to follow guidance to help ensure people were consistently supported safely. This was of particular risk and concern because the home was using a lot of bank and agency staff. We saw an example of temporary staff not being aware of people's specific needs and any associated risks when they helped a person who was on a softened modified diet to eat food that had not been modified. Once a permanent member of staff was aware, the plate of food had to be taken away from the person mid meal and replaced with the correct texture food.
- Whilst care planning and risk assessments were in place for people with diabetes, for one person whose

records we reviewed the plan of care did not state what their individual acceptable blood sugar ranges were. Therefore, it was unclear how staff would know what was normal for this person and when to escalate any concerns and seek advice from healthcare professionals.

Using medicines safely

● People's medicines were not always managed safely. Records relating to the administration of medicines (MAR) required improvement. This put people at risk of not having received their prescribed medicines and the registered provider could not be sure that people received the medicines they were prescribed.

● Where medication administration records indicated that one or two tablets can be given the records did not always indicate how many had been given

● Staff were making amendments to MAR charts when changes occurred, but this had resulted in some administration instructions not being clear or legible. This increased the risk of errors occurring.

● There were gaps in the records for some medicines and prescribed topical creams. There was no evidence those people had received their medicines as prescribed.

Staffing and recruitment

● Suitable arrangements were not in place to ensure there were enough staff to give people the care and support they needed. One person commented, "They definitely need more staff. The staff are very good, but they're overworked. More than anything else they need more staff. When they're busy it may be half an hour before they come. When I sit here and want to go to the toilet, and they don't come I get into a bit of a muddle." Another person said, "I feel guilty [using call bell] because they are so busy. Some mornings I have to wait quite a while; more than 10 minutes and some mornings I've waited more than 20 minutes. There are a lot of people here who need two people to help them and you have to wait longer if they can't get a second staff member. It's more noticeable on weekends and in the mornings when people are getting up and having breakfast."

● Relatives and nearly all staff also told us that staffing levels were not sufficient to provide the support that people needed. One person's relative said, "There is a lot of people here who need two carers to help them. I've been here when [family member] has been waiting 15 minutes to go to the toilet."

● We found some people received personal care later than they wished and some people were left in bed when it was not clear that this was their preference. At 11.45am one person who was sitting in their bedroom in their pyjamas told us they had been waiting a long time for assistance to wash and dress. We had to intervene and find a member of staff to help the person.

● The majority of staff told us they regularly felt stretched, under pressure and frequently worked short staffed which meant there was a task led focus as opposed to the person-centred care and support they wanted to provide. One member of staff said, "Staff morale is low at the moment. We're told to manage our time better, but we can't rush people's personal care and we can't rush people to the toilet. I feel guilty as I have to help people and rush off when they'd love to chat." Another member of staff told us, "I can walk the length of the building twice over and I can't find a member of staff. Now, if I can't, relatives and residents certainly won't. It feels horrible as it's not the care staff's fault. They are not bad staff here, they just need more time and more of them."

● A healthcare professional expressed their concerns about the staffing levels at the home. They described that when visiting it was frequently challenging to locate staff because they were always very busy. They also told us how relatives had also raised concerns with them that their family member did not receive their care in a reasonable timeframe.

● A 'dependency tool' was used to help calculate how many nursing and care staff were needed and deployed across the home. Although the home was being staffed in line with the recommendations of the dependency tool the feedback we received, and our observations showed that there were insufficient staff to meet people's needs in a timely manner and provide person-centred care based on their individual

preferences.

Failure to deploy sufficient care staff to promptly provide people with the care to meet their needs and preferences is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were not always protected by robust recruitment procedures. Whilst the provider had safe recruitment and selection procedures in place these were not always followed at a local level at the home.
● For two members of staff at the home the provider could not assure themselves that at the point of recruitment pre-employment references were obtained from their previous employer. In addition, for some staff, records did not always demonstrate their full and continuous employment history. These shortfalls had reduced the provider's ability to assure themselves about the applicants' previous good conduct.
● The shortfalls in the recruitment and selection of staff had increased the risk people would not always receive care from trustworthy members of staff.
● The provider took immediate action during the inspection to ascertain where staff references had been supplied from and to assure themselves that staff were being recruited safely. In one case they prevented a member of staff from working temporarily whilst they obtained the correct reference. This shortfall was not identified through the provider's own checks and would not have been addressed without the concerns being identified during our inspection.
● The managing director reassured us that a full audit of all recruitment files would also be undertaken by the provider's human resources department and that further training, for staff at the home, would be undertaken in the process of recruiting staff.

Systems and processes to safeguard people from the risk of abuse
● We received mixed feedback from people and their relatives regarding whether they felt safe living at Alice Grange or not. Where they were concerned, this was attributed to the staffing levels and not having enough staff available to meet people's needs which made them worry at times. One person said, "I've been alright myself, but over the last few months I've wondered if there's enough [care staff] on to look after us at night."
● Staff were not always encouraged to speak up and raise concerns externally relating to the provider. Prior to our inspection we were told, anonymously, of a letter that had been sent to all staff working at Alice Grange by the manager. Concern were expressed with us that the letter was discouraging staff from raising any concerns about the standards of care at the home in the form of whistleblowing. A whistleblower is a member of staff who reports within an organisation or externally to a professional of a colleague's wrongdoing. We saw copies of the letter on staff files during our visit and whilst it did not explicitly tell staff not to raise any whistleblowing concerns it could easily have been interpreted that this was the message. This did not assure us that staff felt able to raise concerns, in an open culture.

Learning lessons when things go wrong
● People were at risk of avoidable harm as accidents were not analysed and lessons not learned, or improvements made. Whilst there was a process in place for managers to assess the accident or incident to look at reducing the likelihood of a reoccurrence, the manager told us up until they commenced at the home the previous manager was asking staff to complete this piece of work themselves.
● Following a recent safeguarding concern at the home the manager told us of the lessons they had learned and the actions they had taken to make the necessary improvements. New care planning documents had been put in place and appointments with a healthcare professional was in the process of being arranged and offered to each person. These improvements were in their infancy at the time of the inspection.

Preventing and controlling infection

● We saw that all areas of the home were clean, tidy and odour-free. A team of house keepers were employed to carry out domestic tasks across all three floors.
● All staff received training in the prevention of infection and had access to personal protective equipment such as disposable gloves, aprons and hand sanitising gel.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

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

Supporting people to eat and drink enough to maintain a balanced diet; Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's hydration needs were not being properly monitored and recorded to ensure unnecessary dehydration and weight loss. For people at risk, their fluid intake was not consistently recorded or totalled in order that their consumption be monitored.
- People were not always protected from risks of poor nutrition due to insufficient record keeping. For example, a number of people had lost weight, some significant amounts over the previous six months. However, despite healthcare professional advice being that they should be offered fortified food and snacks, there were no records to evidence this was occurring.
- We found that several people had been assessed by a Speech and Language Therapist (SALT), but there was no guidance available to staff in their care plan to show what action was needed following the assessment to prevent people from risk of choking.
- People's relatives told us they were not sure that the changes being made on Memory Lane were positive. One said, "I'm not sure whether the new meal time arrangement worked today. People were saying "Has so and so had her dessert?" and so on and they gave the impression that they didn't know who had eaten what and what was happening, it seemed a bit chaotic to me."
- People's care was not provided in line with published guidance and best practice. Although the tools the home used to assess people's needs were nationally recognised, they were not always used effectively and with detailed record keeping in place.

Improvements were required to ensure people's nutritional and hydration needs were met. This demonstrated a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- We observed lunchtime and the mealtime experience. People told us they enjoyed the food and that there had been improvements in the quality. One person said, "The food is good; there's always enough and I have a choice." Another person commented, "The food has improved; very much improved. Before it wasn't very appetising and now it's more the sort of food I like."
- The manager told us they had introduced a new lunch time meal service on Memory Lane in the past week and that the previous two dining rooms had been merged into one so that all staff working on that floor could work together.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other

agencies to provide consistent, effective, timely care
● Whilst people had access to healthcare professionals, their care plans were not always updated to reflect the outcome and any subsequent advice. This meant people were at risk of not having appropriate care and support.
● Other healthcare guidance had also not been consistently followed. For example, in relation to the required support to reduce the risk of pressure ulcers. The use of prescribed topical medicines had not been consistently used or recorded.

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.

● Although staff sought people's consent and they were respectful of people's right to make decisions about their care, the home was not sufficiently staffed which restricted people's ability in having those decisions and choices implemented.
● Where restrictions were in place in order to keep people safe, an application was made to the local authority DoLS team.
● Discussions with staff demonstrated they recognised when people were potentially being deprived of their liberty and appropriate applications had been made for legal authorisation.

Staff support: induction, training, skills and experience
● Staff had not consistently had supervision from a member of the management team or nursing staff. This meant opportunities to manage performance, discuss any work concerns and support development may have been missed.
● Staff told us they had not felt supported at work for a while. One staff member said, "We do have supervision with the unit manager, it is useful, but it can be a long time between them. Sometimes we are so busy we don't get time to sit down and raise concerns with them."
● Staff continued to have access to training. The manager told us of their challenge to ensure all staff updated their training as required but told us 90% compliance with the providers mandatory training was now being achieved.
● Nursing staff had access to relevant clinical skills training. This included medication and catheter care to ensure their skills were up to date. We found however that this training did not transfer into good care and support being delivered to people and called into question the nursing staff professional capability.
● Learning was available to staff using face to face training and eLearning and included moving and handling, safeguarding adults and dementia awareness amongst a variety of others.

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

● The premises continued to be fully accessible and well maintained. There was wheelchair access throughout and suitable adaptations, such as specialist bathing equipment.

● People's bedrooms were homely and personalised. There were various lounges and seating areas for people to use across the home these included a quiet lounge where people could have appointments or meet with family and friends should they have wished to.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. 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; Respecting and promoting people's privacy, dignity and independence

- At our last inspection we were concerned that whilst people told us of the caring and kind nature of individual staff, they were having to wait for support because staff were rushed due to staff shortages.
- Before we carried out this inspection, we received information from a number of sources which indicated that some people living at the home still might not be receiving appropriate care due to the levels of staffing.
- Whilst we observed some kind and caring interactions between staff and people who lived at the home, staff were busy and often task focused. One person commented, "The staff are very good, but they're overworked."
- We observed a high majority of people being left in their room or in bed particularly on Memory Lane. Staff interaction was prompted by the person requiring assistance with care needs or, staff offering people food. This meant that some people spent long periods of time alone without any quality interaction. One person, who was still waiting for assistance with their personal care at 11.45am told us. "I would like to get up early. I would like them to help me to get up earlier."
- People's personal information, such as their care records, were not always stored securely. This meant people's privacy was not always maintained. In an office on one of the floors we found the door left unlocked and an array of people's confidential support notes and records left out on the desk. This area could easily have been frequented by relatives and visitors who would have had ample opportunity to pick up and view any records should they have wished to.
- Staff were kind and caring when interacting with people and their relatives spoke fondly of individual staff members as being friendly, caring and cheerful. One person said, "Both the nursing staff and the carers are lovely. I get on well with them." Another person's relative commented, "The staff are really good, and they spoil [family member] rotten!"
- We observed staff promoting people's privacy by shutting doors when supporting people with personal care.

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

- People were not encouraged to make their own day to day decisions about their care, we found people could not always get up or go to bed when they wanted to because staff were not always available to help them.
- The manager told us they were starting to introduce 'resident' meetings, so people had the opportunity to express their views. The provider had not recognised the need for this based on feedback from the last inspection.

Inadequate

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has deteriorated to Inadequate. This meant services were not planned or delivered in ways that met people's needs.

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

- People's needs were not appropriately assessed or planned for and this had the risk of potential impact on their health and wellbeing.
- In addition, staffing shortfalls and a high usage of agency staff resulted in people's needs not being consistently met. People continued to tell us about being left in bed when they wanted to get up and not being able to get to the toilet in a timely manner when they needed to.
- Not all care plans contained sufficient information to ensure staff knew how to deliver people's care according to their preferences and in a person centred way.
- Care plans were subject to regular reviews however these were not effective because they still did not reflect people's needs as they changed over time.
- People who spent time in their rooms, as well as those who were living with dementia or who were cared for in bed, were more reliant on staff to meet their needs. However, due to staff's workload and their resulting task-focussed approach this meant that people were at risk of social isolation. One person told us, "I do get visitors, but I do feel lonely sometimes and I wish staff had the time to sit down and talk to me."
- During the inspection we observed there was a lack of activities for people living on Memory Lane. Many people were in their bedrooms throughout the day. The two activities co-ordinators, whilst enthusiastic and resourceful, were two staff trying to ensure the social needs of up to 69 people were being met.
- At the time of the inspection one person was being supported with end of life care.
- People's end of life care plans lacked detail. Improvement was needed to include more detail to ensure people's wishes were recorded and known to the staff supporting them.

The service had failed to ensure people using the service received care or treatment that is personalised specifically for them. This demonstrated a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

- A number of concerns and complaints had been raised with Healthwatch Suffolk, the local authority and CQC about standards of care at the home. These concerns had been passed to the home but there had been a failure at provider level to take appropriate action in response to these.
- The provider had a complaints policy, which set out how complaints would be investigated and the timescale for responding. This had not been occurring in practice.

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 considered as part of their care plans however the plans were not always reliably up to date and detailed enough to enable staff to meet these needs. This was of particular concern on the dementia unit where people experienced difficulties expressing their needs independently. This was also a concern in relation to the use of agency staff unfamiliar with people's needs.

● Information in pictorial format and large print was available to accommodate communication needs if required.

Inadequate

Is the service well-led?

Our findings

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

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

At our last inspection we were concerned that quality assurance systems were not always being completed and did not identify the concerns we identified during our inspection. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvement had not been made at this inspection and the provider was still in breach of Regulation 17.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The home was not well-led, there were significant shortfalls in the oversight and leadership which led to poor standards of care. For example, people's care records were not always completed and updated to ensure staff had the right guidance to support people safely.
- There had been a high number of management changes which had destabilised the service and provided inconsistency.
- People were at risk of receiving unsafe, poor quality and inadequate support. At this inspection we found the provider continued to be in breach of three Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; 12, 17 and 18. We identified further breaches of Health and Social Care Act regulations 9 and 14.
- Internal communication was found to be poor at this inspection, and this had contributed to the staff and management's inability to identify and resolve issues. There was ineffective communication between the previous regional manager and previous registered manager, meaning concerns had not been shared with the wider provider organisation. Consequently, there had been minimal oversight of how actions were progressing.
- Audits had not identified issues, consequently these had not been addressed. Care plan audits had not identified the issues found in relation to risk management of nutrition, hydration and skin care.
- The provider had not fulfilled their responsibilities as the registered entity with the CQC in monitoring and ensuring there were adequate staffing levels to support people safely and to meet their preferences. This lack of oversight had led to the quality of care deteriorating.
- People and their relatives were not complimentary about the management arrangements or changes at the home. One person's relative said, "There's been a big turnover of management and each new manager introduces changes which disrupts routines. The present manager has only just come in. Generally, if I had a problem I would talk to the senior carer or registered nurse." Another relative commented, "They're on their fourth manager in 18 months and they're always running short of staff. The staff have told me that they've

been told not to talk to other people about how the home is run. This home has good facilities and it should be run better."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open

● Several relatives told us the provider had not always acted openly when something had gone wrong.
● A recent boiler failure had resulted in a period of time at the home with no hot water. The provider had failed to notify CQC of this under an 'events that stop service' notification.
● We were made aware of the concern by a relative who contacted us to express their concerns at the lack of communication.
● Further relatives we spoke with during our inspection visits also expressed issue with the communication. One relative said. "They didn't tell us about the problems with the boiler which must have caused problems with [people's] personal care. It's not good enough to slip it in at a relatives meeting." Another relative commented, "The hot water problems should have been sorted out earlier. There's also been problems with the laundry. They've cut back on the staff and got others in to help who don't always seem to know what's going on."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider had not ensured there were regular opportunities for people and their relatives to feedback and engage openly about their experiences. This had been recognised by the manager who told us she had already improved communication with relatives and staff and had provided updates on the home and changes being made.
● Staff however were not all positive about communication methods within the home and told us improvements were needed to how communications were shared and the management approach.
● The customer relationship manager, who worked across a number of the providers services, told us of their links between the home and the community. For example, we were told, "We work closely with a local dementia alliance and have a dementia café at the home once a month for people and their families."

Continuous learning and improving care
● The provider had previously had a system in place to gather feedback about the home. This had included contacting people and their relatives as well as staff to seek feedback.
● The manager told us that the last quality assurance survey had been undertaken in 2018 however there were plans to introduce this again from April this year. This meant that the provider had not sought people's feedback to understand their experiences of their care and support and identified any actions needed. Following our inspection the provider informed us the last survey had actually been completed in the summer of 2019.

Working in partnership with others
● The home worked with key organisations, such as the GP's and speech and language therapy. Records, however, did not support that all advice was implemented and followed to ensure good outcomes for people.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive personalised care in response to their needs.

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 People's care and treatment were not always planned and managed in a way that promoted the health, safety and wellbeing of people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People did not always have their nutrition and hydration needs fully assessed and any risk mitigated against.

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 The service did not have robust and effective systems in place to monitor, assess and improve the safety and quality of service being provided. The serious and varied nature of the breaches of the five regulations we have identified demonstrate a failure of leadership and governance at the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The deployment of staff was not sufficient to ensure that people's needs were met in a timely manner.