HC-One No.1 Limited

The Red House Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
The Red House Care Home provides accommodation for people who require nursing or personal care. People may be older, living with dementia and may have physical disabilities. The care home is registered to provide care for up to 60 people across two buildings. Each building provides accommodation over two floors. There were 47 people living at the service at the time of this inspection.

People's experience of using this service and what we found
The service was not well-led. The provider did not operate safe and effective governance systems which meant people were at risk of harm. The provider did not respond to their own quality assurance findings to promote safety and improve care.

There were not enough staff to meet people's needs. People were not protected from harm and lessons were not learnt when things went wrong. Risks to people's safety were not appropriately assessed or reduced by staff, and oversight was not effective. Medicines processes were not safe, and staff failed to appropriately respond when a person displayed symptoms of an infection.

People were at risk from dehydration and malnourishment. People experienced weight loss which was not effectively recognised and responded to by staff. Peoples needs had not been appropriately assessed and agreed health plans were not always followed. Staff had not received effective training to keep people safe, and staff supervision methods were not effective.

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

People were not always treated with dignity and respect by staff. Kind and considerate care was not always evident.

People, or their relatives if appropriate, were not always supported to be involved in the care planning process. Care plans were not developed for people living with dementia. Responsive care planning did not take place for people who experienced deterioration. Social opportunities, engagement and activities were not regularly available for people who remained in their bedrooms.

However, people told us they were supported with their medicines and received pain relief when it was required. People said they were happy with the quality of the meals which were provided and told us staff were friendly and kind to them.

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

Rating at last inspection
The last rating for this service was Good (report published 3 April 2019).
At this inspection we found the service had deteriorated and the rating has changed to Inadequate.

Why we inspected
The inspection was prompted in part due to concerns about safe care and treatment; safeguarding, staffing, nutrition and hydration, person-centred care, privacy and dignity and good governance. We had undertaken an inspection at another of the provider's locations and found these breaches of regulations were present. Furthermore, we had received concerns that common themes may be present at this location. A decision was made for us to inspect and examine those risks.

We found evidence during this inspection that people were at risk of harm from these concerns. Please see the safe, effective, caring, responsive and well-led sections of this full report.

Enforcement and Recommendations
We have identified breaches in relation to safeguarding people from abuse; safe care and treatment; staffing; nutrition and hydration; person-centred care; dignity and respect and good governance 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

The Red House Care Home

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was carried out by two inspectors, a medicines specialist 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.

The Red House Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. The Red House Care Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

At the time of our inspection there was a registered manager in post, however, they had not managed the service since the beginning of July 2022.

Notice of inspection
This inspection was unannounced. Inspection activity started on 3 August 2022 and ended on 5 September

2022. We visited the care home on 3 August 2022, 8 August 2022 and 10 August 2022.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and commissioners of the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
During our visits we used observations to help us understand the experience of people who could not talk with us. We spoke with 11 people who used the service and 17 relatives. We received feedback from an external healthcare professional who had contact with the service and provided support to people.

We spoke with 23 members of staff. These included care staff, senior care staff, agency nurses, catering staff and administration staff. Furthermore, we also spoke with the deputy manager, an interim home manager, a clinical support nurse, two regional directors, the managing director and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We had frequent contact with the interim manager, the clinical support nurse, two regional directors and the managing director during this inspection. We will refer to them as the provider's representatives throughout this report.

We reviewed a range of records during the inspection, this included recruitment documentation for two staff, agency staff proforma's and induction records. We also reviewed care records for seven people and viewed medicine and supplementary records for multiple people during the inspection. We also asked the provider's representatives to send us different records so we could review these away from the care home. These records included care plans, risk assessments, monitoring documentation, staff rotas, staff training and supervision records. Additionally, we requested some policies and other records relating to the management and oversight of the service.

We held video calls with some of the provider's representatives and the nominated individual in addition to our visits to the care home.

Inadequate

Is the service safe?

Our findings

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

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

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- Systems and processes were not robust to protect people from abuse. Staff had completed safeguarding training, however, incidents where potential abuse occurred, such as unexplained skin tears and bruising, were not reviewed, recognised and reported correctly.
- The provider and their staff failed to identify and appropriately respond to neglectful practice. For example, one person was administered two different types of blood thinning medicines when they should have received one. This had placed the person at increased risk of bleeding and poor outcomes.
- Another person had experienced significant unexplained bruising which was not reported to management for 10-days. We requested this person's records and found our request prompted the completion of an incident report and investigation. This meant the person's injury had not been formally reported and reviewed for a total of 16 days after staff first saw it. The provider's representatives concluded the bruising had likely been the result of inappropriate and unsafe manual handling practice by staff. The delay in action, reporting and reviewing of this incident meant other people had also been at risk of receiving unsafe care during that time.
- The provider did not review and monitor staff practice to ensure lessons were learnt when things went wrong. One person experienced an injury when staff left them alone in their bedroom in a wheelchair. The incident was reviewed, and staff were told the person should not be left in their wheelchair "unattended". However, we found another occurrence later took place, and the person again experienced an injury after being left in their wheelchair alone in their bedroom.
- We had substantial concerns which related to the providers oversight of the service and staff practice. We were not confident the provider acted promptly to ensure lessons were learnt and people's safety was promoted. We completed four safeguarding alerts to the local authority to share our concerns for multiple people during the inspection timeframe.

Systems and oversight were not robust to protect people from potential abuse. People were at risk of harm and responsive timely action. The provider did not act promptly to concerns to ensure lessons were learnt. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Using medicines safely

- People were at risk of weight loss, and dehydration, due to ineffective risk assessment and inadequate response to concerns. We found many people had lost weight in the months prior to our inspection, however, responsive action was not evidenced, and people were at risk of further weight loss. For example, staff had failed to follow care plan instructions to refer one person back to health professional services if they lost a specific amount of weight.

● People were not effectively reviewed and supported with fluid intake. Where people's records indicated they had not met their daily fluid intake target, no responsive action was recorded as taken. During, and in the weeks prior to our inspection timeframe, the United Kingdom was experiencing a heatwave. We found people did not have support, assessment and monitoring to keep them safe. One person had required assistance from the emergency services due to dehydration, and we found other people were also at risk due to inadequate support.
● People were at risk of pressure sores and skin deterioration. On all three of our inspection visits there were concerns surrounding pressure relieving mattresses. We found staff did not respond when alarms sounded to identify faults with equipment. We found mattress settings were not always correctly set for the person's weight, and records completed by staff did not evidence meaningful checks took place.
● Furthermore, we were not confident repositioning records were a factual reflection of the support provided to people. For example, we reviewed one person's records, which evidenced they were 58 minutes overdue for staff support with repositioning. This concerned us as the person had a pressure sore. We later reviewed the same person, and their records, and found an entry had been documented for a time prior to our initial review. This entry had not been present on our initial review and did not reflect the person's position at that recorded time.
● People were at risk of falls. Risk reducing measures were not always implemented and people did not always receive adequate support and oversight from staff. We found a high number of falls had occurred at the service, and incident and accident forms did not always evidence a timely and thorough review took place. For example, we found incident reviews did not always consider if a person's risk reducing equipment had been in place and working, or whether the person had received the support and safety checks required.
● Relatives shared concerns with us. One relative told us their family member had been without their falls alarm mat for months as it was "being repaired." Another relative said their family member sustained an injury following a fall when they mobilised without their walking frame. They told us staff had not been present in the communal lounge which meant their family member had not received the required supervision and reminder to use their walking aid.
● Medicines oversight was not safe. One person was unable to have their pain relief as it had run out. Another person was unable to have their antibiotic medicine as it could not be located and was thought to have been discarded by staff.
● People were at risk of poor health outcomes due to ineffective procedures when medicines were received at the care home. An unexpected blood thinning medicine was received for one person. Staff did not review this, and the person was administered two different blood thinning medicines for two consecutive days. This error was identified by CQC's medicines specialist and had not been identified through the providers own processes.
● Medicines administration was not safe. We observed a member of staff disturb a nurse who was preparing medicines for administration. This was not due to an emergency; it was to talk about their weekend. This did not evidence medicine administration was a protected duty to promote safety and staff concentration.

Assessments had not been completed, or were not robust, to mitigate risks to people's health and well-being. Systems and processes were not in place to ensure the safe management, oversight and administration 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.

● Some people told us they received good support with their medicines. One person said, "My medicines are explained to me, including [medicine] that I am now on after a fall a month ago." Another person told us they received pain relief as needed.

Staffing and recruitment

● Safe staffing levels were not robustly assessed, or reviewed, which placed people at risk of harm. There was not enough staff to meet people's needs. During the inspection timeframe we found concerns relating to staff availability, for example, to support people with hydration and nutrition, and their personal care. The provider's representatives told us safe staffing levels were determined using their 'clinical risk register'. We found the clinical risk register was not reflective of the needs of people, and despite reviews taking place, we found continued inconsistencies throughout the inspection timeframe.
● Staff deployment was not safe. We found at least 14 people were left in communal areas with no staff presence during a staff meeting. Some people were resting in bed and we saw other people enter their bedrooms and disturb them. There were no staff available to supervise and support these people. We requested staff deployment be reviewed during the meeting due to our concerns.
● Furthermore, safe staffing procedures were not in place to ensure people were supported during staff changes. For example, day staff left the service at the end of their shift, and no procedures were in place to first ensure night staff had arrived. Three agency night staff were 20 minutes late for their shift, and effective contingency plans were not in place. We were told whilst handovers took place, a member of staff from the previous shift would remain for 15 minutes to provide support to people. This arrangement was not reflected in our observations, nor the staff rotas we reviewed.
● We received mixed feedback about staffing levels. For example, one staff member told us, "There are staffing pressures. Staffing is not enough for the dependency of the residents and the checks and support needed. A lot of people require hoisting, it can be difficult." Another staff member said, "Staffing levels are better. [Shifts are] covered by regular agency staff who have been here forever and are really good and friendly." A further staff member told us staffing levels were "poor" but said the agency staff who worked at the service were "fantastic."
● Relatives also had mixed views about staffing levels. One relative told us, "They do seem short of staff sometimes, and staff have said that to us as well." A further relative said, "I think there is enough staff."
● We observed people waited for support, and their needs were not always identified and met in a timely manner.

Robust systems were not in place to calculate and review staffing requirements at the care home. There were not enough staff to meet people's needs. This was a breach of regulation 18(1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● During the inspection timeframe the provider's representatives reviewed and updated the clinical risk register, and staffing levels were increased during the day and overnight. However, we found there were continued inaccuracies when the clinical risk register was reviewed, and we therefore could not be confident staffing levels were appropriate.
● The provider undertook specific checks when recruiting staff. This included Disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. This information helps employers make safer recruitment decisions.

Preventing and controlling infection
● We were not assured that the provider was preventing visitors from catching and spreading infections. The requirements of rapid COVID-19 testing changed during the timeframe of our inspection. However, on one occasion when we visited the care home staff did not check our rapid COVID-19 test result. This was at a time when it was required in line with government guidance and the providers own procedures. We were told by staff they had not checked professional visitor rapid COVID-19 test results "for months."
● We were not assured that the provider was supporting people living at the service to minimise the spread of infection. One person had symptoms of an infection on their return from hospital. Staff communication was ineffective, and information had not been handed over to protect other people from potential infection.

● We were therefore not assured that the provider was responding effectively to risks and signs of infection as no infection control procedures had been implemented nor considered.
● We were also therefore not assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were also not assured that the provider was admitting people safely to the service.

We found no evidence people had come to harm; however, infection control processes were not robust. This was a further breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Inadequate

Is the service effective?

Our findings

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

At our last inspection we rated this key question Good. At this inspection the rating has changed to Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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

- People were at risk of malnutrition and dehydration due to inadequate provision and support. There was not enough staff to support people with their nutritional and hydration needs. Oversight was not effective, and risks to people were not acknowledged. People had not received robust assessments, and when weight loss occurred, this were not shared with the kitchen staff to ensure their awareness for additional support to be provided.
- People had unexplained weight loss and we shared our concerns with the provider's representatives who, in response, requested 10 additional people received fortified meals and snacks whilst reviews and dietician referrals took place. We observed staff question why those who did not appear underweight needed this support. This did not demonstrate staff had awareness or understanding people may present as a healthy weight but be malnourished. Furthermore, this evidenced a lack of concern for unexplained weight loss.
- The provider did not have effective processes to offer and assist people to receive snacks and nutritional intake between their evening meal at 5pm and breakfast the next day.
- Staffing levels did not promote regular and appropriate timed provisions of snacks and nutritional supplements. Staff told us drink and food provisions between meals could be late, and this impacted upon people's appetite and meant they did not eat their meals.
- Furthermore, staff told us the drink and snack trolley round was sometimes not completed and not everyone was offered a snack and drink. We observed this to be the case on one of our inspection visits. This further identified concern for ensuring people received suitable nutrition and hydration intake to support their health.
- Fluid charts evidenced people were not robustly monitored and supported to ensure their intake was enough to keep them comfortable and hydrated. For example, we found one person had a recorded daily intake of 120mls to the time of 4pm. Staff had not recognised the person had not drunk very much and needed encouragement to drink more. Another person was receiving treatment for an infection, their fluid intake record had not been completed correctly and could not be relied upon. The record indicated the person had drank much more than they had and meant staff were not encouraging them to increase their fluid intake.
- On the first day of our inspection there was a time delay of approximately 1 hour and 30 minutes for some people to receive their lunch time meal. The cook had attended training during the morning and no consideration had taken place for the impact this caused to people and their nutritional intake. We observed people became restless whilst waiting for their meal and they considered leaving the dining room without eating. People in their bedrooms did not know when their meal would arrive.
- Relatives expressed concern for the support provided to their family members with eating. One relative

said, "[Person] is on a normal diet but is unable to chew, we don't know what encouragement [person] gets to drink and eat enough." Another relative told us they were concerned how people with dementia were helped to select the right meal. The relative said their family member received a diet of a normal consistency, however, they were unable to chew their food. The relative further told us of an occasion when their family member was unable to chew the meal provided to them, and described the meal as "like cardboard." A replacement meal was provided, however, the relative said they were sure a replacement would not have been given had they not been there.

We were not assured people were supported to eat and drink adequate amounts to promote their health and well-being. Intake records were not reviewed, and responsive action to concerns was limited. This was a breach of regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some people told us they were happy with the quality of the meals they received. One person said, "I like the food, there is always something I like." We saw staff showed people plates of food in the dining room to help them make informed choices.

Staff support: induction, training, skills and experience
● Staff had not completed the training required to undertake their roles and keep people safe. We found agency staff induction was not a thorough process, and staff appraisals had not been completed in line with the providers policy.
● The provider's representatives told us agency nurses received induction when first working at the service, and medicine competencies were completed. However, we found one agency nurse at the location had not completed an induction and had regularly worked at the care home. The provider had not received information from the agency about this agency nurse which meant they could not be sure of their skills, qualifications or experience. Furthermore, no medicines competency had been completed, and the nurse had been involved in a medicine error during our inspection.
● The provider failed to monitor and appropriately address training shortfalls. For example, we found only 76.8% of staff were compliant in nutrition and hydration training, and food safety compliance was 75.8%. Whilst other training courses also required completion, we found significant concerns in relation to nutrition and hydration which demonstrated staff had not completed effective training.
● Staff appraisals had not been completed annually in line with the providers policy. The provider's representatives told us of their 58 staff employed, 41 were overdue an appraisal, 31 of which had not received an appraisal during their employment. This meant staff did not have annual opportunity to reflect on their employment, learning needs and personal development in line with the providers procedure.

We found robust systems were not in place to ensure staff support, training, skill and experience. This placed people at risk of harm. This was a breach of regulation 18(2) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People's needs were assessed prior to them living at the care home. However, we found effective and timely reviews to support people's health did not take place, and oversight was ineffective.
● For example, we found care plans and risk assessments were not always reflective of people's circumstances, and some people's risk tools, used to assist with risk assessment processes, were not correctly completed and calculated. This meant people were not robustly assessed for risk reducing

measures to be fully explored and implemented. Furthermore, conflicting information was present within people's records which did not evidence staff completed thorough reviews.
● People's changing needs, and support requirements, were not always recognised due to the ineffective assessments undertaken. This resulted in weight loss not being appropriately recognised. We found timely referrals to health professionals did not take place. For example, one person had met the specified weight loss criteria in June 2021, however, a referral did not take place until April 2022 and the person had experienced further weight loss. Another person had significant weight loss within a short timeframe, and despite their weight being recorded by staff, we found a referral to the dietician was delayed. Interim measures to support the person to increase their nutritional intake did not take place.

People had not received effective and appropriate assessments. Furthermore, responsive timely action was not taken to refer people to specialist healthcare services. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
● The provider had failed to complete appropriate health and safety environmental checks. We found areas of the service required decoration, and damage to walls and doors had not been acted upon. The providers policy stated six monthly health and safety audits should be undertaken, however, an audit had not been completed since June 2020.
● The provider's representatives did review the environment during our inspection timeframe and told us an extensive refurbishment would be undertaken. Furthermore, the provider's representatives said people would be consulted to ensure their inclusion in decoration plans.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.
In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● The provider's systems to assess and review people's mental capacity and decision-making abilities had not always been followed. One person had incomplete best interest and capacity assessments for wound care and support with medicines. This meant they had not received an assessment to determine if they had the capacity to make decisions surrounding their care and support needs.
● We found capacity and best interest assessments had not always been completed at a supportive time of day, or with enough time taken between each assessment. For example, one person had an assessment recorded as taking place at 10pm. Another person had assessments with only a five-minute timeframe recorded between them. This did not evidence people were always given appropriate time and support to consider the information provided to them as part of the assessment process.

● A DoLS application and authorisation tracker was available which allowed staff to monitor authorisations in place, and those which had been applied for.

Inadequate

Is the service caring?

Our findings

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

At our last inspection we rated this key question Good. At this inspection the rating has changed to Inadequate. This meant people were not treated with compassions and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care

- People were not always treated well and supported with their needs. We found people did not always receive the respect, privacy and dignity which was due to them.
- Staff did not always consider people's privacy. We observed staff did not always knock on people's bedroom doors before entering. Furthermore, we observed staff entered people's bedrooms to speak with other staff and did not always acknowledge the person the bedroom belonged to.
- Another person was receiving personal care from staff when a member of staff briefly knocked on their bedroom door and walked straight in. This did not show respect for the person nor did it evidence dignified care. We also observed a person walking without their mobility aid, staff approached them, placed their walking frame in front of them and said, "Here, use this," the staff member then walked away.
- People were not always treated with compassion and consideration. On one of our visits we found loud music was playing at 7am and staff were talking around the nurse's station about their tasks for the day ahead. People's bedroom doors were open, and this did not promote a dignified and respectful environment.
- People were not always supported to make daily decisions about their care. One person was cared for in bed and told us they would like to spend time in communal areas. We viewed their records which stated the person wished to be cared for in bed. There was no evidence to demonstrate how this was reviewed with the person.
- Staff did not always provide personalised support and reassurance. We observed one person coughing and asked staff if the person needed assistance. The staff member handed the person some paper towels from a bathroom and left the room. Furthermore, we found people were not always provided with prior communication and reassurance before being assisted to move in their wheelchairs.
- Staff spoke about their duties without consideration for the privacy and dignity of people. We found some staff were task focused which showed little consideration for people. For example, we heard staff say, "Declined, declined, declined. Well, I have done my side!" when reviewing people's support records. Furthermore, we heard staff read a written request to encourage people with their fluid intake, and they said, "Please push fluids? Well that is okay, but what about my break?"
- Staff did not always speak about people in a respectful way. For example, we heard one member of staff communicating with other staff in a corridor, they said, "I am great, only two more people to do personal care on!"

We found robust systems, supervision and management observational checks were either ineffective or not in place. This placed people at risk of receiving care which was neither respectful nor dignified. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● On the first day of our inspection one person's birthday had gone unnoticed and was not celebrated. We brought this to the attention of staff in the late afternoon as this did not demonstrate a personalised approach to care. However, we found other people's birthdays had been celebrated and one relative praised staff for their efforts to celebrate occasions during the pandemic. The provider's representatives reviewed people's birthdays and ensured these were shared with relevant staff departments at the care home.
● Despite our findings, and observations, people and their relatives told us of positive care experiences they did have. For example, one person said, "The carers are kind and look in on me a lot." Another person said, "I am well looked after."
● Relatives told us, "[Person] is very settled, the carers are fantastic." Another relative said, "The staff are friendly." A further relative said, "[Person] is looked after well and is always clean."
● One person's relative told us they had requested only female staff assisted their family member with personal care. They told us this took place.

Inadequate

Is the service responsive?

Our findings

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

At our last inspection we rated this key question Good. At this inspection the rating has changed to Inadequate. This meant services were not planned or delivered in ways that met people's needs.

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

- People, and their relatives, if appropriate, were not always involved in the care planning process. This meant people's preferences and opinions were not regularly sought, and care plans were not always reflective of their needs and preferences.
- People with a diagnosis of dementia did not have a care plan in place for this health condition. The provider's representatives told us this was to reduce a focus on the condition, and to consider the person as a "whole". We found this approach did not promote a person-centred approach to care, as the person's individualised needs had not been assessed, and their specific type of dementia had not been clearly identified to provide guidance to staff.
- Staff told us they did not have time to access and read care plans. This meant they were not always confident regarding the changing needs of people. One member of staff told us, "No, we don't have time to sit and read [the care plans], we are busy. I sometimes try to read them during my break."
- Relatives told us they did not always receive updates on the changing needs of their family member. One relative said they had previously been advised they would be involved in the care planning process, however, received no further contact. One person and their relative said they had not been involved in their care planning since the person moved into the care home.
- Care plans were not up to date and were being reviewed by the providers clinical support team during our inspection timeframe. Despite this being the case, we found people, and their relatives, had not been provided with an opportunity to be part of this process. Furthermore, we found regular staff were also not included which meant there were missed opportunities for them to develop their practice.
- The provider had an end of life care policy available, and staff had received end of life training. However, we found improvements were required to recognise expected health deterioration and ensure responsive care planning took place.
- One person's health deteriorated during the inspection timeframe and a further decline was medically expected. However, care plans had not been developed in recognition of this and to guide staff in how to meet the person's needs and wishes. We spoke with the provider's representatives and they told us specific care plans were not implemented unless a person was in the final days of life. This did not demonstrate responsive care planning took place to ensure people's needs and wishes were continuously reviewed and explored.

We found people, and their relatives, were not always involved in planning care which met their needs and preferences. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People had 'remembering together' booklets. These booklets contained people's life history and were completed by relatives with/ for people to aid reminisce and conversation. We found some very detailed booklets had been completed, however, these were held in care plans which were not regularly accessed by staff. We spoke with the provider's representatives during the inspection and recommended they make these more accessible to encourage opportunities to 'remember together'. During the inspection timeframe staff made copies of these booklets to place in people's bedrooms.
● People had allocated key workers and support carers allocated to them. This was to assist with building relationships and to assist with communications. Of the relatives we spoke to, one relative told us, "We live a distance away so can't visit often but [keyworker] rings us every month with an update, and if anything happens, they contact us straightaway."
● We found people's bedrooms were personalised and reflected their preferences.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● People were supported to take part in activities and follow their interests, however, the activities schedule and support provided did not meet the needs of all people. We found activities did not always take place as scheduled.
● People who were unable to attend communal activities experienced periods of time without social interaction, and often the engagement they did receive from staff was task based. Weekly activity programmes were available at the care home; however, we found the one to one activities provided to people in their bedrooms only took place one morning per week.
● Scheduled activities did not always take place. On our third inspection visit a general staff meeting was held in the afternoon which the well-being staff attended. This meant the planned activity of 'bread making' was not provided, people had been left without engagement and many were seen to fall asleep in their chairs. This did not demonstrate to us social support and activities were a priority at the care home.
● When communal activities did take place, those able to attend told us they enjoyed them. People engaged with each other and we observed staff supported them with activities such as bingo, arts and crafts and using an electronic activities table.

Improving care quality in response to complaints or concerns
● The provider had a complaints procedure, however, we found concerns were not always appropriately acknowledged for responsive action to be taken. For example, one person's relative wrote to staff to advise them of action they had taken in response to a concern they had for their family member. Staff had not acted upon this letter and we found it filed it within the person's care plan.
● People and relatives told us they knew how to raise a concern or complaint, and these were acknowledged by staff with responses provided.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.
● The provider had systems in place to ensure documentation was available in different formats to support people's communication needs.
● Care plans and 'resident profiles' contained information about people's communication needs to guide staff on the support they required. However, feedback from relatives did not always suggest due care was taken with their relatives' communication aids. For example, one relative told us, "Two sets of hearing aids

and a pair of glasses with [person's] name on them have gone missing."

Inadequate

Is the service well-led?

Our findings

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

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

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Working in partnership with others

- The findings of this inspection did not evidence people experienced positive outcomes, and they were not protected by the providers governance systems. People's needs were not always correctly assessed, recognised and responded to. We found appropriate reviews of staffing levels had not taken place which impacted on safety and the care people received.
- The provider's governance systems were ineffective, and people were at risk of harm. For example, the provider's own quality review in January 2022 highlighted a concern people were not receiving enough food and fluids to meet their needs. It also identified people had experienced weight loss. The provider's representatives, and the nominated individual, told us action was not taken following this quality review, this meant risks to people remained, and we found people continued to experience weight loss. This did not demonstrate a commitment to safeguarding and responding to concerns, nor dedication to continuous learning and improving care.
- Furthermore, monthly medicine audits had consistently failed at the service since April 2022. This meant effective action was not taken to ensure staff practice improved and to promote safety. We also found the provider had not completed six monthly health and safety audits in line with their own policy. The last recorded audit had been completed in June 2020.
- Effective systems were not in place for safe and appropriate storage of people's records, and some records we requested could not be located for our review.
- Oversight, analysis and procedures were not robust. Safe working systems were not clear, nor embedded in practice. We found failures in many areas, which included: nutrition and hydration provision to people; appropriate risk identification and response; care planning; accident and incident reviews; safeguarding processes; medicines management; and staffing.
- The provider had not worked in partnership and effectively communicated with external organisations. For example, they had failed to make referrals to the local authority safeguarding team and external healthcare professionals. This put people at risk of harm and poor care.
- We carried out an inspection at another of the provider's local care homes during June to September 2022. During that inspection we found similar themes and issues which did not demonstrate the provider undertook prompt reviews of their other service locations to ensure effective action was taken and lessons were learnt.
- At this inspection we found breaches of regulation relating to safe care and treatment; staffing;

safeguarding service users from abuse and improper treatment; meeting nutritional and hydration needs; person-centred care; privacy and dignity; and good governance. These widespread failings did not demonstrate to us the provider had effective and safe oversight of the service they provided, nor did it demonstrate an understanding of regulatory requirements for the safe care of people.

The provider had failed to consistently assess, monitor and mitigate risks to people's health, safety and welfare. The provider had also failed to improve the quality of the service through their own governance systems and processes. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager was not present at the care home during the inspection timeframe and they had not managed the service since the beginning of July 2022. The provider had made interim management arrangements for support to be available at the care home. This included an interim manager, and a clinical support nurse. Both representatives were experienced registered managers who were employed at two of the providers other registered locations. Furthermore, during the inspection timeframe we also noted additional management support was present at weekends.
● Staff told us they found the interim manager and clinical support nurse were approachable and supportive. Furthermore, staff told us they felt able to approach the interim management team should they have concerns.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People, relatives and staff told us they had not been formally approached for their feedback or insight of the service provided. The provider's representatives said they were developing a new feedback system to ensure this was sought.
● During the inspection we found a resident and relative meeting had taken place, however, these meetings had not been a regular provision prior to our inspection. People and their relatives told us they were unaware of the current management arrangements at the care home. One person said, "I've not seen the manager and I don't know if there are resident meetings." One relative told us they had met the interim manager, but this was when they made a complaint and they had been unaware of any changes prior to this.
● Relatives commented they often faced difficulties contacting the service by telephone. One relative told us, "The manager does get back to me if I leave a message. However, it can be difficult to get through sometimes." Another relative said, "It can be difficult to get through on the phone, even in normal hours."
● Staff told us they had opportunities to attend staff meetings, however, said these were not always at accessible times for their work patterns. The provider used an electronic staff messaging system, however, staff told us they did not always read the messages as they sometimes felt overwhelmed by the quantity received. The provider's representatives told us they would review the volume of messages sent to staff to improve the effectiveness of the system.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider's representatives were aware of their responsibilities to be open and transparent. Throughout the inspection process our findings were reviewed, acknowledged and several areas were acted upon without delay.