Barrels UK Care Ltd

The Firs Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
The Firs Residential Care Home is a residential care home providing personal care up to a maximum of 29 people. The service provides support to older and younger adults, people living with dementia and people who have a physical disability. At the time of our inspection there were 21 people using the service in one adapted building. There is a shared lounge, a dining room, and a conservatory on the ground floor. Bedrooms are single occupancy and are on the ground and first floors.

People's experience of using this service and what we found
The quality of the service provided, the external building and internal facilities and décor had significantly declined since the last inspection. The provider once again failed to have a robust oversight of the service, this included when repairs were required and when safety concerns were raised. The provider failed to appropriately respond to promote safety and improve care quickly enough.

Fire safety risks, cleanliness concerns and environmental health risks to people found during this inspection meant that the CQC made referrals to the fire safety service and environmental health.

The provider had failed to learn from the 4 previous CQC inspections of this service since they registered in September 2018. This demonstrated to us that the provider had little understanding of the Health and Social Care Act 2008 Regulations and what standards were required to achieve compliance and provide good accommodation and a good service to the people in their care.

Accidents and incidents records did not give enough information to establish any patterns and trends and what action was required to reduce the risk to people. The governance system and audits in place to monitor the quality of the service provided were not robust. Actions to make improvements including improvements to safety were not acted upon quickly enough to reduce the risk of harm to people. Improvements made during the time the provider had registered with the CQC, were not embedded, or sustained to keep people safe and well cared for.

The had been numerous manager changes at the service during 2023. As such, people and their relatives had mixed opinions about communication in the service, as they were not always updated as to who was in charge. Some people and their relatives felt their suggestions and concerns were acted upon and some told us they did not feel listened to.

There were not enough appropriately trained staff to meet peoples' complex needs. As such, staff although kind towards the people they supported, were working in a task led approach. Lessons were not learnt when things went wrong, and as such, people were not always protected from harm. Safety risks following incidents were not appropriately identified, reviewed, and acted upon by staff. Again, the provider oversight of this was not robust, safe, or effective.

Due to the changes in management, staff had not received regular supervision. People's relatives also told us that relatives' meetings, where they could receive updates about the service had also stopped taking place.

People's meaningful social opportunities, engagement and activities were limited, and this put people at risk of social isolation. This meant people spent long periods of time without stimulation.

The new computerised care record system did not robustly show that people's records, including their dependency needs were updated following health changes, changing needs and or following a significant incident. People's care records used to guide staff held conflicting information in them. People, their relatives where appropriate were not supported and or encouraged to be involved in their, or their family members care decisions and reviews.

In the main people were given choices and this choice respected, however this did not happen all the time and we found there were missed opportunities. People enjoyed their meals and were supported to eat and drink. However, robust records of people at risk of weight loss and any actions taken to reduce this risk were not in place.

In the main, people were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests.

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 service is now rated Inadequate. This service has been rated requires improvement for the last three inspections (published 27 May 2022, 24 December 2020, and 17 October 2019). The service was also previously rated inadequate (published 25 May 2019).

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about the cleanliness of the service, staffing, lack of staff understanding about safeguarding people and supporting peoples known risks, the state of disrepair of the building internally and externally and a general lack of financial investment by the provider. 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 and other concerns. Please see the safe, effective, caring, responsive and well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Firs Residential Care Home on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to safeguarding people from abuse; safe care and treatment; premises and equipment; staffing; person-centred care; 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.

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 of their registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

The Firs Residential 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.

Inspection team
This inspection was carried out by 2 inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
The Firs Residential Care Home is a 'care home.' People in care homes receive accommodation and personal care as a single package under one contractual agreement dependent on their registration with us. The Firs Residential Care Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 28 September 2023 and ended on 24 October 2023. We visited the service on 28 September 2023 and 10 October 2023.

What we did before the inspection
The provider did not complete the required Provider Information Return (PIR). This is information providers are required to send us annually with key information about the service, what it does well and improvements they plan to make. We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used all this information to plan our inspection.

During the inspection
During our site visits we used observations to help us understand the experience of people who could not talk to us. We spoke with 5 people who used the service and 4 of their representatives. We also received feedback from healthcare professional teams who had contact with the service and provided support to people.

We spoke with 7 members of staff. These included the interim manager and deputy manager, care staff, a team leader, catering staff and domestic staff. We spoke with the owner who was also the nominated individual. The nominated individual is the provider, and therefore responsible for supervising the management of the service. Furthermore, we also spoke to a representative of an external agency working with the service.

We reviewed a range of records during the inspection, this included recruitment documentation for 4 staff. We also reviewed care records and risk assessments for 4 people and viewed medicine records during the inspection. We asked the interim manager and deputy manager to send us other records which we reviewed away from the service. These records included care plans, risk assessments, quality monitoring documentation, staff rotas, complaints, compliments, accidents and incidents, and staff training records. Additionally, we requested other records relating to the management and oversight of 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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Preventing and controlling infection; Learning lessons when things go wrong

- People were at risk of harm because the provider failed to take prompt action. During this inspection, the Care Quality Commission (CQC) were told the fire alarm had been turned off at approximately 3.00pm 27 September 2023 (the day before). Rapid action had not been taken by the provider to ensure people's safety by organising urgent repairs. We raised our significant concerns with the provider and made clear that the fire alarm needed to be working by 28 September 2023. We also made the Cambridgeshire Fire and Rescue Service aware of all the fire safety concerns found during the inspection. The lack of prompt action by the provider put people, visitors to the service and staff at an increased risk of harm.
- As the fire alarm had been switched off, all fire doors that had pin coded access on them were not secured. This meant that these doors were open allowing people to come and go freely. This included the fire door situated directly at the top of the back staircase in the building. This increased the risk of people with poor mobility, having access to and falling down the stairs.
- People were at risk of harm. An external fire risk assessment dated 24 June 2023 had identified that actions were needed to repair and or replace some fire doors at the service by 22 July 2023. The provider could not evidence this had been actioned.
- A bedroom door, which was also a fire door and the surround had been damaged during an incident. This had not been replaced to ensure fire safety compliance. There was no incident form to demonstrate learning from this incident. Again, these lack of prompt actions and lack of learning put people, their visitors, and staff at an increased risk of harm.
- People were at risk of injury. A person known to be at risk of increased agitation had their wardrobe in their bedroom pulled away from the wall. As the wardrobe was not secured and had been moved, this increased the risk of the wardrobe either being pulled onto, or falling, onto people. There were no risk assessments undertaken by the provider to review this risk to the person or other people who had free standing furniture.
- People were at an increased risk of harm as known risks and agreed actions, including consistent guidance, were not always followed by staff. People's care records were both paper and computer based. Information to guide staff around people's known risks such as supporting people to go outside and or smoke outside safely had conflicting information in them.
- A person told us their cigarettes were found under their pillow when their care record clearly stated that staff were to hold their cigarettes and lighter due to risk.
- There were no clear actions recorded by staff to document steps taken to support people who were losing weight. As part of the monitoring of people's risks, staff weighed people to monitor their weight gain or loss. However, for people at risk of losing weight, these records did not demonstrate what actions had been taken to support these people safely or their ongoing progress.

● Prior to the inspection we were made aware of a fly infestation at the service. Whilst pest control services were involved, people told us about the continued fly infestation. One person said, "The place is full of flies, it is disgusting. It is horrible when you have your meals, and all the flies are there."
● We found the kitchen was visibly dirty, a bin overflowing, had out of date food and food not labelled. There was also a fly infestation within the fridge in the kitchen and the staff fridge. As such, we made a referral to the local authority Environmental Health team.
● People were at risk of poor infection control practices. Three hand gel dispensers were empty on the first floor; some equipment used to support people was seen to be unclean. We also found areas of the service including shared toilets and bathrooms were visibly unclean. We observed that a person's personal items such as toothbrushes were left on top of a dirty sink.
● Flooring on the ground floor was significantly damaged. As such, these floors would be very difficult to keep clean due to the cracks and damage. Also, a staff member was seen using the same disposable gloves to support several people without changing their gloves. All of this increased the risk to people at the service of poor infection control practices.

The provider had failed to ensure people had safe care and treatment. Systems had not been established or embedded to assess, monitor, and mitigate fire safety risks to people using the service. Work to make the service compliant with the fire safety regulations had not been carried out quickly enough. There was conflicting information to guide staff on how to support people safely. Areas of the service and equipment were visibly unclean. This placed people at a continued risk of harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People had a personal emergency evacuation plan (PEEP) in place. This would guide staff on the assistance needed to help evacuate people safely in the event of an emergency such as a fire. However, some of these records had not been reviewed since 2021 to factor in any changes to people's dependencies.

Systems and processes to safeguard people from the risk of abuse
● The provider had failed to safeguard people by making sure that staff had the skills to deescalate increased agitation resulting in safeguarding incidents occurring. As such, a person ended up throwing a piece of equipment through their window. This incident meant that during this time, the person, and other people, including staff were at a significant increased risk of harm.
● The provider put people at risk by not taking prompt action. The provider failed to organise the boarding up of a significantly broken window (very large hole) in a person's room. This window had been damaged during an incident. The broken window had been left not boarded up from 13 September 2023 to 27 September 2023. This put the person and people entering the room during this time, at risk of harm.
● Systems and processes to guide staff were not robust to help protect people from abuse. The provider lacked oversight of the service and had failed to identify that not all safeguarding incidents had been reported. One staff member told us that they had to go back through incidents and report historic concerns. They said that safeguarding incidents had not always been reported to the required agencies.

The provider had failed to safeguard people from the risk of abuse and harm. This placed people at a continued risk of harm. 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.

● Records indicated that most staff had safeguarding training and had completed their yearly refresher training.

Staffing and recruitment

● Staff did not always have the skills and knowledge to support a person with increased agitation. Staff could not evidence that people's care records and risk assessments were updated following significant incidents. This included a person who was involved in altercations and had caused physical harm to another person at the service. Analysis of incidents and accidents showed that this person had a significant number of altercations during a two-month time period. This demonstrated to us that there were not enough skilled staff to meet this person's needs to help reduce the risk of these incidents.

● The provider had failed to identify staff lacked skills, confidence, and knowledge to effectively support people living with complex agitation and dementia. There were not enough staff to manage a person's risk to themselves and others. We noted that a hospital letter dated 13 March 2023 gave instructions that a person should have 1-2-1 staff support during certain situations. The dependency tool that determined the level of staff support required for this person was dated 28 February 2023 and rated low. During this inspection we did not see the 1-2-1 staff support required. The interim manager told us that they had not been made aware of this requirement and that this additional staff support was not happening at this time.

● The provider had undertaken a recruitment campaign to reduce the amount of agency staff used. However, the provider lacked oversight that there were not enough staff to ensure people were safe. During the inspections second site visit we overheard a loud escalating verbal altercation between 2 people in the dining room. We had to locate staff to intervene.

The provider had not made sure there were enough staff available to meet people's needs and promote their safety. This included additional staff support for people when required to keep themselves and others safe. This was a breach of regulation 18 (1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● 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. However, not all gaps in potential new staff's employment had been explored.

● Robust pre-employment check records were not always held. Previous employment references did not always have the full name of the person giving the reference, who they worked for and in what capacity they knew the person. We made the interim manager and deputy manager aware of this.

Using medicines safely

● Senior staff were trained to manage and administer people's medicines for those people who had been risk assessed as requiring this support.

● People and their relatives had no concerns around staff's competency to administer people's medicines safely. However, most people told us that whilst they had no concerns, their medicines when administered were not explained to them. A person confirmed, "[Staff] don't explain my medication. I just take it. They haven't ever run out of it."

● 'As required' medicines records included information to guide staff. 'As required' medicines are given when needed, for example for pain relief or for increased anxiety. However, information to guide staff when a person was becoming increasingly agitated did not direct staff on what distractions to use first, before resorting to the 'as required' medicine.

● Senior staff audited people's prescribed medicines. Medicines were stored securely, and temperature checks were undertaken to ensure the room did not get too hot, so the medicine remained effective.

Visiting in care homes

● Relatives confirmed that they could visit the service to spend time with their family member.

● Relatives told us, and we experienced during our site visit days that the gate to the front of the building was at times very difficult to open. A relative said, "You can wait for ages to be let through the gate. I have had to ring the service to ask to be let in." Another told us about the gate, "An elderly visitor of my [family member] has been unable to get in and has left."

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.

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

- Prior to the inspection we received concerns about the significant lack of investment by the provider. We found that the provider had failed to make sure that the building both externally and internally was in a good state of repair. This included the fixtures and fittings. The furniture and décor in the service was in places in need of significant repair and or replacement. A relative said, "The chairs are old and low, and [family member] struggles to get out of them... I want [family member] to keep their life skills and independence for as long as possible."
- There were numerous windows broken at the service. This included a shared toilet window and windows in some people's bedrooms. The provider had failed to repair the broken windows quickly and in 1 person's room, staff had used tape to cover the cracks. A relative confirmed to us, "[Family member's] window is broken with tape over it. [The provider] should have fixed it by now."
- A communal bath had no taps, there were bedroom doors where the handles had been broken off and the ground floor had damaged flooring which could pose as a trip hazard. The conservatory which was supposed to be a shared room for people to use was sometimes locked.
- The provider had failed to ensure that people lived in a safe environment. We found rubbish and broken equipment piled up in the garden. The walkway to the smoking area consisted of a damaged and uneven pathway. People who smoked were risk assessed as being at risk of trip hazards, so this significantly increased this risk to them.
- The boiler at the service had not fully worked since December 2022, and this meant some people's radiators and hot water in their rooms didn't work (8 rooms). Where some rooms had radiators that did not work, there was free standing oil filled heaters. These got very hot to touch and would be a significant scald risk should a person touch or fall against them. A relative said, "Radiator does not work so [family member] has two oil heaters to heat the room."
- A washing machine had stopped working in June 2023 and had not been replaced. There was storage under the back stairs including wheelchairs and a mattress which was a fire hazard.

Due to a significant lack of funding by the provider the external building, surrounding areas and internal fixtures and fittings were not safe or of a suitable standard for people. This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- The provider had failed to ensure that staff had continued to receive regular supervisions during the numerous manager changes at the service. Supervisions are formal conversations held with a line manager

to discuss staffs' performance and any additional support and or training required. A staff member said, "We have had manager changes. [I've] just had a supervision with (named new manager) and, previously supervisions have been sporadic due to manager changes."
● In the main staff had completed their mandatory training. However, we found some staff lacked the skills, knowledge and understanding to meet some people's needs. In particular, people with complex agitation due to their dementia and or mental health needs. This meant that there were some significant incidents that occurred at the service.

The provider failed to ensure staff received appropriate training and regular supervision for their role. This was a breach of regulation 18(2) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● People were not always provided with person-centred support to make meal choices and were not aware of daily menus. People's communication needs had not been considered, as pictorial menus on show did not always show the correct food on offer. For example, the pictures for lunch were a roast meat with vegetables and a chocolate tart. However, a sausage plait or a bowl of baked beans with bread and butter followed by rhubarb crumble and cream was the food served.
● People told us, and we saw that people seemed to enjoy their meals. A person said, "The food is alright. You can choose what to have in the morning. You can get a drink when you want and [staff] check up to make sure you have drunk it." However, we also found that staff did not support people with person centred care by giving people the option of having gravy and or cream with their meals. The food was plated up already with gravy and cream for people without the choice being given at the time the meal was served.
● People's dietary needs, linked to specific health conditions, were not recognised, and considered in people's care records to guide staff. For example, a person with diabetes did not have reference to this in their food and fluid records.

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 had lacked oversight since the numerous manager changes during 2023, which meant that we found that 1 person's DoLS authorisation had run out on 29 May 2023. There was no evidence that this had been reapplied for. This meant that the person had unlawful restrictions in place.
● Prior to the inspection, we had been made aware of concerns that staff did not have a thorough understanding of the principles of the MCA. We found that staff in the main understood people's right to make choices and have these respected. A staff member told us they had completed the training. They said,

"People are presumed to have capacity and if they don't you help them in their best interests."

● People told us, and we observed that people were in the main given choices and that these choices were respected. A person confirmed to us, "I make my own choices about what to wear and what to do."

● However, we also saw missed opportunities for staff to ask people for their choice for example plates being already plated up during mealtimes. We also witnessed a person who was mid conversation with a member of the inspection team being moved away by a staff member with no explanations or choices given.

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

● A visiting health professional told us they were confident staff followed their guidance and advice when caring for people.

● In the main people and their relatives talked us through the input they had when needed when accessing health professionals including the GP. However, 2 people told us separately that they had asked to see the GP, but this request had not happened. A person said, "The only thing is the pain I am in, and they haven't let me see a doctor, which I don't understand."

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

● Staff told us that all new guidance and legislation was printed off and put onto the staff notice board for them to read.

● Peoples' care plans and daily records were both paper based and computerised records. We found that sometimes these records contained conflicting information. It was also unclear on the computerised records when they had last been updated. This included whether they had been updated following a health change and or significant incident. As such, this increased the risk of staff not working with up-to-date information to support people safely and effectively.

Requires Improvement

Is the service caring?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- Due to a significant lack of provider funding, whilst we saw that staff in the main were kind towards the people they supported, the service itself was not a caring environment to accommodate people in. The provider had allowed people to live in a building, which included fixtures and fittings, which were in a significant state of disrepair. One relative told us, "We bought [family members] own mattress in as the mattress was appalling. I didn't give them the opportunity to say yes or no, I just did it. There were springs poking through the old one."
- In the main people spoken with told us that staff were kind and caring when supporting them. A person said, "The staff are very good. They are really caring and will always help you." Although another person told us, "Most of the staff are alright. Sometimes you get some who are a bit bossy or short with you."

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

- Records documented that people had chosen to not be involved in the review of their care records. There was no evidence to demonstrate how staff encouraged people to be involved. People told us that staff did not support them to be involved in these conversations. People confirmed to us that, "I can't recall any discussions about my care or getting to know me. I suppose it just happens in day-to-day chats." And, "I don't know anything about talking about my care." This increased the risk that people's preferences and current individual wishes were not known nor acted on.
- Due to the numerous manager changes at the service the provider lacked oversight meaning there had been a level of inconsistency with communication. A relative told us, "(Communication regarding family members care decisions). This has changed lately and not as good as it was."

Respecting and promoting people's privacy, dignity and independence

- A relative told us that staff did not always promote their family members independence. They said, "Staff have told [family member] it is ok to go (to the toilet) in your pad. [They are] not encouraged to not wear a pad and to go with support to the toilet when needed." They went on to say, "Home smells of urine when you walk in." The strong malodour was found during our 2 inspection site visits. This did not demonstrate to us this was a service that supported people's dignity.
- People, or their representatives, were not given opportunities to decide who supported them, their family member with their personal care. People told us and their care records did not always explore or record people's choice of staffs' gender to support them. A person told us, "They haven't said that I can choose a male or female [staff]. I do usually get a female which I do prefer."
- In the main we saw staff, wherever possible, support people with reassurance. A person said, "[Staff]

always knock on the door and wait for you to shout out. They talk nicely to me and don't try and make me do things I don't want to." We saw some nice interactions when a person was hoisted. Staff, all the time giving the person they were supporting words of encouragement. However, we also observed a missed opportunity for a staff member to promote a person's dignity by rearranging their trousers that were falling down.

Requires Improvement

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 requires improvement. At this inspection the rating has remained requires improvement. This meant people's needs were not always met.

At the last inspection the provider was in breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This meant that people did not always receive person centred care and support from staff. Staff did not always meet people's needs and had become task led. At this inspection there had been some, but not enough improvement made.

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; End of life care and support

- Relatives were concerned that there was not enough for family members to do to keep them meaningfully occupied to promote their social inclusion. They told us that their family members avoided social isolation only due to the visitors they had.
- People did not always receive personalised care and support. Staff continued to work hard, but there was not always enough staff available to deliver person centred, individualised care for people that promoted social inclusion. A relative told us about their family members isolation at the service. They said, "My concerns are that at 2.30pm my [family member] was still in bed. I want them to be in the lounge re social interactions and not just left in bed. I found them still in their nightdress 2.00pm on Sunday afternoon. That means from 3pm – 7am [family member] is in bed and left in their room. At (named age) [family member] does not deserve this."
- End of life care plans seen did not always include evidence of an in-depth consideration of wishes where deterioration may occur quickly. Evidence was not available to identify if this had been explored with people and or declined.
- The language seen with a person's end of life care plan referred to the person being supported by a nurse. This service is a residential care home without nursing. As such, these records were not robust enough. The records failed to ensure staff had enough guidance on what type of nurse should be requested to support people to have as dignified a death as possible, in line with their wishes.
- People and their relatives had mixed opinions about the activities that took place. They told us that the activities were not very person-centred and individual. A relative said, "In the afternoon they play the good old times music (such as) 'roll out the barrel' etc re the second world war. My [family member] is [named age] that music is [family members] parents generations music. [They] would want to listen to rock and roll and country and western." Another relative told us, "[Family member] sometimes play dominoes. [Family member] thinks activities such as colouring is childish."
- The notice board that displayed the activities taking place during our inspection did not match what was listed. During the second day we heard a singalong of war time songs that care staff and people who wanted to take part seemed to enjoy. However, the music being played was in direct competition with the just as

loud radio music being played in the adjoining dining room.

The provider failed to ensure people's care met their individual needs. People's social, emotional needs, and preferences had not been assessed and considered, including their end of life wishes. People did not always receive person centred care and support from staff that met their individual preferences and holistic needs. This was a continued breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● People living with dementia or sensory impairment had limited orientation aids available within the service. This increased the risk of people being disorientated because the environment and signage had not been fully designed to meet their needs. A relative told us, "[Family member] is room [number given] and they haven't even put a picture of [family member] up outside."
● The provider had failed to develop the service in line with the assessable information standard. During the inspection we asked for evidence of information being made available in a way people would understand and none was provided.

Improving care quality in response to complaints or concerns
● The numerous numbers of management changes at the service in 2023 had meant that people and their representatives were not always clear on who to raise any concerns with.
● People and their relatives told us they had not seen the complaints process which should detail how the provider would respond to any complaints and within what timescales. People said, "I can't remember being given any information," and, "I don't think I have had any information."
● We asked for copies of the complaints made during 2023 and were sent a record that documented complaints received during May and June 2023 only. The records did not document the nature of the complaint. This meant that the provider and management could not use these records to have oversight of any patterns and trends to take any necessary actions needed to improve the service.
● People and their relatives told us that they would speak to the care staff if they had any concerns. A relative told us of the negative response they received when raising a concern about the service. They said, "I worry now about complaining in case they take it out on my [family member]."

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 requires improvement. 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.

At our last inspection the providers governance system and audits had failed to identify the areas that required improvement. Any improvements were not always sustained and embedded. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection a robust governance system continued to not be in place.

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

- The provider failed to ensure there was a registered manager at the service. As a condition of CQC registration this service must have a registered manager in place. During this inspection 2 managers left at different times. As such, the service continues to be without a registered manager. People told us, "I am not sure who the manager is now," and, "I don't know who it is," and, "I don't really know who to speak to now."
- The provider did not have sufficient oversight of the service. A Provider Information Return (PIR) was sent to the service by CQC on 11 January 2023 to be completed and returned by 8 February 2023. This is the second request (previous year 2022 also not completed) that a PIR had not been completed and returned. This is information providers are required to send us annually with key information about the service, what it does well and improvements they plan to make.
- The provider lacked a sufficient understanding of regulatory requirements for the safe care of people. The provider, since they registered with the CQC on 21 September 2018 had failed to achieve compliance with the Health and Social Care Act 2008 Regulations. This demonstrated to us they had a lack of learning from the previous 4 inspections and enforcement of what standards were required to achieve compliance. As such, they continued to fail to provide a good service to the people in their care.
- The provider's governance systems and audits continued to be ineffective; this had placed people at risk of harm. The provider failed to ensure there was sufficient investment at the service. Significant improvements required were not actioned quickly enough to ensure the accommodation and standards of care provided to people were safe, effective and of a good standard. A relative confirmed to us, "They can't keep the managers. So, what is happening to the service users?"
- The provider continued to lack oversight of the standards people should expect when living at the service. During this inspection we found multiple breaches of regulation. These widespread failings demonstrated the provider was not able to embed and sustain previous improvements.
- The providers governance system had failed to identify that a person during the months of July and August 2023 had 9 'altercations,' some of which could be safeguarding concerns. The records lacked detail and were unclear. We found that there were no safeguarding notifications submitted for any of these

altercations. As such, there was an increased risk that the provider had failed to ensure that all incidents and events they were obliged to notify the CQC about had been reported.

The provider's governance system and audits had continued to fail to identify the areas that required improvement. Any improvements made, were not always sustained and embedded. This is a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Some relatives told us that due to the numerous numbers of manager changes at the service that communication was not good. This included when their family member had been involved in an accident or incident. A relative said, "[Family member] has had a fall, they did not inform me straight away as they could not find my contact details, but staff told me when I next visited." Another relative told us, "I have a right to make sure [family member] is cared for. It is not the [staff] necessarily they do care for [family member]. It is the way it is run. You get no updates or contact as you don't know who you are going to speak to next."

● Relatives told us that since the management changes there had not been a relatives meeting held. These meetings would communicate and engage with people, their relatives and representatives and give crucial updates on what is happening at the service. A relative said, "[I] was not informed that there was a new manager."

● Surveys sent out to people and their relatives in April 2023 had no action plan to demonstrate what improvements would be made because of these surveys and by when.

● Staff at the service had mixed opinions on whether they felt supported. A staff member said, "[Deputy manager] is very professional and takes pride in their role." However, another told us, "The residents are suffering…[The] trees outside are never cut. Residents never get outside. People are cold in the winter. Only 1 washing machine working. The last 2 weeks, no maintenance, no proper cook, no proper manager for 7 months."

Working in partnership with others

● The service has been working with an external consultancy firm. The service also has a service improvement plan in place from working with the local authority.

● The manager and staff team worked in partnership with a range of external health and social care professionals such as social workers and GPs to promote people's well-being. However, records of this were not always recorded in enough detail.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not made sure there were sufficient numbers of staff available to meet people's needs and promote their safety. This included additional staff support for people when required to keep themselves and others safe.This was a breach of regulation 18(1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider failed to ensure staff received appropriate training and regular supervision for their role. This was a breach of regulation 18(2) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.