Brownlow Enterprises Limited

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

Summary of findings

Overall summary

About the service
Aronmore Residential Care Home provides accommodation with personal care for older people including those living with the experience of dementia and mental health needs. The service consists of a 27 bedded care home and four individual 'cottages' in the rear grounds of the main building. The service is registered for a maximum of 31 people and at the time of our inspection there were 28 people living at the service, 24 in the main building and four in the cottages.

People's experience of using this service and what we found
The provider did not always have effective systems in place to safeguard people from the risk of abuse. Medicines were not always managed safely and staff had not completed medicines competency assessments. Safe recruitment procedures were not always followed, but the provider addressed this after we raised this issue during the inspection. Cleaning schedules were in place, but processes were not always implemented effectively to help ensure staff followed appropriate infection control practices to prevent cross infection.

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 supported this practice. Care plans were not always personalised so staff knew how to respond to people's individual needs appropriately. Meaningful recreational activities for people to help prevent social isolation were limited.

The provider had quality assurance systems in place to monitor and manage the quality of service delivery. However, these were not effective as they had not identified the various areas we identified during our inspection as needing to improve and the provider had therefore not been able to improve the quality of the service.

Staff were supported to develop their skills through supervision and training to help them deliver appropriate care to people.

People were supported to access healthcare services. People and their relatives told us people were cared for by kind staff who knew the needs of the people they cared for.

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 (published 24 October 2017).

Why we inspected
The inspection was prompted in part due to concerns received about the quality and safety of care. This was

followed up by the local authority who alerted CQC of further concerns around staffing, lack of social activities, and the oversight and governance of the service.

We looked at infection prevention and control measures under the safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well led sections of this full report.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to person centred care, privacy and dignity, consent to care, safe care and treatment, safeguarding people from the risk of abuse an improper treatment, safety and suitability of the premises 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.

We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Aronmore 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 Care Act 2014.

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

Inspection team
The inspection was conducted by two inspectors, a nurse specialist advisor 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
Aronmore Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

At the time of the inspection, the service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. Since the inspection the registered manager has left the service and the deputy manager was promoted to the manager's post and had applied to CQC to become the registered manager. In this report by manager we are referring to the deputy manager.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. This included the last inspection report and notifications received from the provider. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We sought feedback from the local authority and professionals who work with the service. We used all of this information to plan our inspection.

During the inspection
We spoke with ten people who used the service and one relative about their experience of the care provided. We spoke with five members of staff including the deputy manager, a senior care worker, care workers and domestic staff.

We reviewed a range of records. These included five people's care and medicines records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to inadequate

This meant people were not safe and were at risk of avoidable harm.

Using medicines safely
• Medicines were not always managed safely. We observed the morning medicines round was not completed until 11:55am and the lunchtime round started at 12:30pm. This was only 35 minutes between rounds and meant there was a risk that people may not be getting their medicines as prescribed. One person told us they did not get their medicines at the right time at night, they said, "Sometimes I wait for my medication at night".
• The provider did not have a process where a staff member administering medicines should, as far as possible, not be disturbed to prevent errors. They were labelling medicines pots with room numbers and told us it was in case they got called away, so they would not forget who the medicines were for. When we asked if they were often called away they said that sometimes they were. We observed when the staff member was called away at one point, medicines were left on top of the medicines trolley in a communal area and accessible to people picking them up and swallowing them. This meant medicines were not being managed safely.
• We observed the manager checking controlled drugs with a member of the domestic team. When we queried this, the manager said the staff member had the relevant training. However, when we asked to see staff medicines competency assessment, these were not available and nor were these forwarded after the inspection. Therefore, the manager could not demonstrate that the domestic staff member or other staff had the appropriate competency assessments to help manage medicines safely.
• The provider did not have a systematic system to audit controlled drugs to make sure amounts were correct and to detect any errors promptly. The registered manager said audits were not undertaken as a running total was kept when medicines were administered.
• Where people have been identified at risk from certain medicines, risk management plans were not always in place to help mitigate risks associated with the medicines.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate medicines were effectively managed. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider had policies and procedures covering the safe administration of medicines. Staff had received training in medicines administration. A member of staff we observed administering medicines confirmed they had received appropriate training.
• Medicines records we viewed were completed appropriately. This included medicines administration records and as required medicines (PRN) protocols. Medicines were securely stored and maintained at safe

temperatures.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
• The provider had systems and processes to protect people from the risk of abuse but these were not implemented effectively to help protect people from avoidable harm and abuse.
• In the 'significant events and incident log' for one person, it was recorded in June 2021, that the person had told their family staff were handling them roughly during personal care. The recorded outcome of the incident was staff spoke with the person who said that it had happened in the past and no longer happened now. The manager's notes said they would address this with the team. However, there was no evidence this was followed up with the team and no learning outcomes to help mitigate future risk. Furthermore, this was a vulnerable person with fluctuating capacity making an allegation about abuse. The provider did not raise this as a safeguarding alert with the local authority or as a complaint from the family. As a result appropriate safeguarding investigations had not been carried out to identify what went wrong so appropriate action could be taken to prevent reoccurrence.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to safeguard people from unnecessary risk and help keep them safe. 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.

• The provider did not have robust systems within the service to learn when things go wrong. They had systems in place to record safeguarding alerts, complaints, and incidents/accidents. However, the records were not robustly maintained or completed and there was no audit trail of any actions taken by the provider to analyse any type of incident or complaint, identify shortfalls and address these. This meant the provider could not demonstrate that learning took place when things go wrong, to help prevent similar incidents from happening again and to improve service delivery.

While we found no evidence that people had been harmed, the lack of robust arrangements around learning lessons from accidents and incidents, safeguarding incidents and complaints meant that people were not always protected from the risk of receiving unsafe care. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Notwithstanding the above, people generally told us they felt safe in the service. One relative commented, "I feel my [relative] is very, very safe and was unsafe at home".
• The provider had up to date policies and procedures for safeguarding and whistleblowing. Staff had received training about safeguarding adults. They understood their responsibilities in ensuring that people were protected from the risk of harm and reporting any concerns.

Assessing risk, safety monitoring and management
• The provider had systems and processes in place to help keep people safe including risk assessments and risk management plans, however the provider had not always effectively assessed risks and implemented risk management plans.
• One person had a history of falls and was known to use the stairs but did not have a risk assessment for using the stairs. This meant, staff had not assessed whether the person was safe to do so or whether additional safety measures were needed.
• Another person who required oxygen, had a stationary oxygen generator. When they walked around outside their room there was a tube trailing behind them connected to the stationary oxygen generator which was a trip hazard for other people.
• Where people had risk assessments, for example for diabetes, these were generic and not always specific to

the person. Therefore clear plans were not in place to address identified risks to people.
• In one bedroom we saw a removable metal back rest on the bed which had gaps fingers could be caught in, however there was no risk assessment for the back rest. Therefore, this risk had not been assessed or mitigated.
• There was not a specific risk assessment for one person who became physically aggressive during personal care. Whilst there was an assessment about risks to others, this did not provide guidance for the staff so they could understand why the person was physically aggressive. There was an emphasis on managing the undesirable behaviour rather than providing interventions, so the person felt safe and less likely to behave in a way that could challenge the service..
• The staff did not always support people in a safe way. We witnessed a member of staff supporting a person to walk using a walking frame. The staff member used an inappropriate technique by pushing the person along, rather than enabling the person to walk at their own pace. This placed them at risk and meant the person was not able to safely control their own speed or movement.
• The provider did not always store potentially hazardous substances safely and securely. We saw nail polish had been left in the lounge which could be dangerous if ingested. The risk of this had not been assessed or managed.

We found no evidence that people had been harmed however, systems were not robust enough to demonstrate safety was effectively managed. This placed people at 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 personal emergency evacuation plans (PEEPs) for how each person should be evacuated and the assistance which was required to ensure people could evacuate safely in an emergency.
• Regular health and safety monitoring of the building had taken place.

Preventing and controlling infection
• We were not assured the service was following infection prevention and control procedures, including those associated with COVID-19.
• People's COVID-19 risk assessments were a list of actions relating to preventative measures such as handwashing, and not actual assessments or tailored to the person with COVID-19 indicators such as ethnicity and age to help assess their likelihood of becoming ill with the virus. There were no risk mitigation plans. Staff did not have individual COVID-19 risk assessments or risk mitigation plans to help address their risk of COVID-19.
• The provider lacked enhanced cleaning schedules and infection control audits to help ensure all areas of the environment were clean and infection free. For example, the provider showed us an audit of mattress cleanliness, but this did not match what we observed during the inspection. Out of 11 mattresses we looked at, four were stained, indicating neither the cleaning schedule not the audits were effective. There were a number of cleaning schedules, but these were not audited so improvements to the service could be made.
• Additionally, we saw people shared slings at the service meaning there was a risk of cross infection.

We found no evidence that people had been harmed however, systems were not robust enough to demonstrate infection control was effectively managed. This was a further breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• There was a COVID-19 control and prevention policy providing guidance for people and staff.
• Staff had received training in infection prevention and control. There was enough personal protective equipment (PPE) for staff and visitors, with procedures for the use and disposal of this. People confirmed, staff always wore PPE when supporting them.

• A 'whole home testing' programme was in operation, which meant everyone who lived or worked at the home was routinely tested for COVID-19.

Staffing and recruitment
• The provider did not always follow safe recruitment practices to help ensure only suitable staff were employed to care for people using the service.
• One staff member's file we reviewed had a criminal records check that indicated a past event that required the provider to risk assess the suitability of the staff member, but this had not been completed at the time of the inspection. The provider sent a risk assessment that was completed after the inspection.
• During the morning of the inspection we observed staff moved from one task to another without much interaction with people. The morning activities were supported by one member of staff only which was not enough to engage the number of people present. We discussed the staffing levels with the manager, and they told us they would review these.
• Most people we spoke with thought there were enough staff but a few thought there could be more staff. Comments included, "Yes, I feel there are enough staff" and "I feel there could be more staff here."
• Staff members received an induction when they commenced working at the home and regular training and supervision was provided throughout their employment.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement.

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

Adapting service, design, decoration to meet people's needs
• There were areas of the environment that did not always the support the delivery of quality care to people. We found that in many places the premises were not adapted to meet the needs of people with dementia and to ensure the environment was safe or suitable for them.
• We observed some communal bathrooms and had rust and peeling paint and bedrooms with peeling paint and furniture that appeared past their useful life and not always appropriate for use. For example, the provider used small, lightweight camp like beds that had the mattress directly on a metal frame. This meant people were not provided with comfortable beds that were suitable for their needs.
• During lunch one person told staff the clock was at the wrong time, but it was not corrected, and we told another member of staff again later that afternoon before it was changed.
• Also, during lunch one person commented that the glasses to drink from were dirty, however it was that they were discoloured from use and age. This person also noted their table wobbled which made it uncomfortable to eat a meal from.
• Although there were a number of people living with dementia, the home did not have a dementia friendly environment to help reduce disorientation, frustration and behaviour that challenges and to help improve people's well-being and independence. (Dementia Friendly Environment, Social Care Institute for Excellence).
• Doors and hallways were not distinctive enough, particularly for a person living with dementia to orientate themselves to their rooms or to recognise doors to other places such as the lounge or the bathroom. The National Institute for Health and Care Excellence (NICE) guidance about environments for people with dementia states, 'Good practice regarding the design of environments for people with dementia includes incorporating features that support special orientation and minimise confusion, frustration and anxiety.'
• The guidance also refers to the use of 'tactile way finding cues.' The government guidance on creating 'Dementia friendly health and social care environment' recommends providers 'enhance positive stimulation to enable people living with dementia to see, touch, hear and smell things (such as sensory and tactile surfaces and walls, attractive artwork, soothing music, and planting) that give them cues about where they are and what they can do.'
• Doors had photos by them, but for every second door in the hall the photo was beside the door before them. This meant every other door had two photos beside them and appeared to indicate shared rooms which was not the case and which could cause more disorientation.
• People's bedrooms were not personalised to individual tastes, so they had familiar things around them

and felt at home.
• Activity lists to alert people what activities were available lacked visual cues which meant not everyone could read them. Similarly, menus on tables were also in printed format without visual cues. This meant people who could not read these were reliant on staff explaining the menu options.

We found no evidence that people had been harmed however, the provider did not ensure all premises and equipment used were suitable for the purpose for which they were being used and properly maintained. This was a breach of regulation 15 (Premises and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• After the inspection the manager told us were going to establish a budget to allow the redecoration of the building to make sure it was more dementia friendly.

Ensuring consent to care and treatment in line with law and guidance

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

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

• We found MCA principles were not always followed. We found where people lacked the mental capacity to make decisions, the provider had not always sought consent from their legal representatives or made decisions in people's best interests along with the involvement of people's relatives and representatives. For example, the 'do not resuscitate form' for one person indicated the person had full capacity and did not want to be resuscitated. However, a care plan created by the local NHS trust indicated the person did not have capacity and the service had not advocated for the person so their rights were upheld. Furthermore, a consent to care form was signed by a relative although there was no evidence to suggest the relative had the legal right to sign the form.
• During the inspection we observed practices which could have been restrictive on people's liberty. This included one person's bedroom door being locked. This meant the person was not being supported to move around the home freely and was restricted in accessing their room.
• Records for another person included a care plan instructing staff to hold a person's hands still whilst another member of staff provided personal care. This was to stop the person becoming physically aggressive. However, there was no risk assessment or recorded best interests decision for this restrictive practice.

We found no evidence that people had been harmed however, the provider did not always follow the principles of the MCA. This was a breach of regulation 11 (Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The manager had made applications for DoLS authorisations so these people's freedom was not unlawfully restricted.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's needs were assessed by the provider prior to moving to the home to confirm these could be met by the provider in line with legislation and guidance. The assessments were then used to form the basis of the care plan.
• Care plans were reviewed but were not always updated to reflect people's current needs. For example, we saw in the records of one person they had vascular dementia diagnosed at the memory clinic but their care plan was not updated with this information and there was no further information about the impact of this condition on the person.
• Care plans included people's background history and some preferences. People's cultural and religious needs were also recorded so staff were aware of these and could consider the information when caring for them.

Staff support: induction, training, skills and experience
• People were cared for by staff who were appropriately trained and supervised. They were supported to keep their professional practice and knowledge updated in line with best practice through inductions, supervisions, annual appraisals and team meetings.
• People described staff as supportive. For example, a relative told us, "I think if [relative] had been at home, they wouldn't be with us, and we are very happy with this home."

Supporting people to eat and drink enough to maintain a balanced diet
• Care plans identified people's nutritional needs including their likes, dislikes and specific needs, such as pureed food.. Where required, people's food and fluid intake were monitored, and people were weighed monthly.
• When people required additional support with eating, drinking or swallowing, the staff had referred them to the appropriate healthcare professionals. However, guidance from the professionals was not always recorded in the care plans. We discussed this with the manager who said they would include this in people's care plans.
• There was availability of drinks within people's reach. Fluid intake was documented on the fluid balance chart, when required. Records indicated fluid and food charts had been consistently completed. This was confirmed by a senior carer who said, "[People] drink well, eat well.…"
• We observed lunch being served and saw people were asked what they would like before being served their choices. People told us, "The food is ok I have had porridge and a cooked breakfast" and "They don't stick to the menu, but they don't do a bad job. The food is ok."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• People were supported to maintain their health and access appropriate healthcare professionals.
• Appropriate referrals to external services were made where required to help ensure people's needs were met. This included the speech and language therapist and the GP, to help ensure people received effective and timely care.
• Care records were maintained as required to indicate the support people received from healthcare professionals and the outcomes of any visits or referrals.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement.

This meant people did not always feel well-supported, cared for or treated with dignity and respect; Supporting people to express their views and be involved in making decisions about their care

Ensuring people are well treated and supported; respecting equality and diversity
• Decisions about where people were supported were not always based on their individual choices and involvement and sometimes on decisions made by staff. We observed that people who required support with lunch were supported to eat in the lounge. People who ate independently ate in the dining room.
•During the inspection we observed the staff did not spend time interacting with people and tended to focus on tasks rather than how people were feeling. We noted people were sitting in the dining room for over half an hour waiting for their lunch with very little interaction. Staff did not have the habit of engaging with people during the day, apart from social activities, which were time limited and only involved a small number of people.
• Staff did not always use appropriate or respectful language. For example, one person was asked if they would like to put on a 'bib' instead of a tabard. Staff referred to people being ''toileted'' and one care plan included the statement, "…[person] understands when staff say [behaviour] is bad".
• People were not always treated respectfully. For example, one person had a tabard put on them without staff asking or explaining what they were doing. At one point another person asked a member of staff for a cup of tea. The staff member told them they would get this at a specific time and not when they wanted one.

This was a breach of Regulation 10 (dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People felt cared for by the staff. Comments included, "The staff are busy but look after me" and "There are a few staff that are a little impatient but mostly they are good. The carers just care; they have done my nails".
• We observed some positive and caring interactions between people and staff. Some staff interactions were gentle and supportive. Although these interactions were limited, they listened and showed genuine interest in what people spoke about when these happened.
• Personal histories were not always documented in the care notes, but staff we spoke with were aware of people's individual backgrounds so they could take these into account when caring for them.
• During lunch we observed one person was served food in line with their cultural requirements, which they enjoyed.
• Care plans had some information about people's likes and dislikes to help staff support people in the way they wanted. In some cases people were supported to make decisions. For example, being offered a choice

of food from the menu.

Respecting and promoting people's privacy, dignity and independence
• People were supported to be as independent as they could and wanted to be. We observed staff encouraging people to be independent, for example encouraging those who could walk to do so.
• People's privacy and dignity was respected, and care was provided behind closed doors. Staff addressed people politely, using their preferred names.
• When one person became agitated and shouting out, the staff were very clam and spoke quietly to them which helped to reduce their agitation.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement.

This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; 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

• Care plans were not always written in a person centred way and did not always have adequate guidelines for staff to provide personalised care. For example, the records for one person stated they could become physically aggressive. Care plans for this person gave inconsistent information and there were no plans to support this person in this respect apart from guidance to restrict their movement when this happened. The lack of an accurate and complete care plan meant that the person was at risk of receiving care which was inappropriate and unsafe.

• The provider used an Antecedent-Behaviour-Consequence (ABC) chart for the above person. In the 'trigger' section they recorded 'personal care', but there was no indication of what specifically the trigger during personal care was. The ABC chart had a record of immediate action taken, however, there was no analysis of the incidents to put a preventative strategy in place or to plan and provide a more personalised approach to care for this person.

• The service had a full time activity co-ordinator, but we observed activities were not always person centred or meaningful. For example, the morning activity during the inspection was a care worker walking around people sitting in the lounge, clapping to children's songs. There was also music playing and the television was on at the same time making it difficult to hear specific activities. One person told us there were only two activities a week.

• We saw in one person's file it recorded the person did not like group activities but did not identify personalised activities they might like. We also noted this was a person who demonstrated behaviour that challenged and would have benefitted from a personalised activity programme, as part of the strategy to help support them with their behaviour.

• The social activity programme was very limited and had activities such as 'laundry folding' every morning. There was no indication that this was according to people's choice and interests or as part of a reablement programme.

• The home was not following the latest guidelines on dementia, for example the University of Stirling guidelines, and people were sitting passively not engaged in an activity. We did not see any sensory activities that people could initiate themselves which meant people were reliant on activity staff for all their activities. This was a missed opportunity to support people in a way that met their needs and promoted their interests. This meant the provider was not always planning and providing social and leisure activities which reflected people's needs and interests.

The provider did not always ensure care was personalised to meet people's needs. This was a breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• We saw staff were knowledgeable about the needs of the people they supported and could talk with them about topics that were relevant to the person, for example their family.
• Some care plans contained information to help meet people's needs and preferences. This included information about people's social history, and which provided staff with context and areas of interest when communicating with the person.

Improving care quality in response to complaints or concerns
• The provider had procedures in place to respond to complaints. People and their relatives knew how to make a complaint.
• People were generally happy with the service and said they knew who to make a complaint to but had not needed to.
• The complaints file contained a record of the complaints, for example in the form of an email, however there was no systematic way of recording and providing an audit trail about how the complaints were dealt with, such as having a clear record of the investigation plan, the findings and how to mitigate the event from happening again. This meant there was little evidence that the provider had systems to learn from complaints. The manager told us they would review the way they deal with complaints to improve this.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

• People's information and communication needs were identified in their care plan, including if they required assistive aids such as glasses or a hearing aid.
• Staff spoke a number of different languages and we observed staff interacting with people in their own language.

End of life care and support
• At the time of the inspection, no one was receiving end of life care in the home.
• Care records contained information to help ensure people's wishes for care at the end of their lives was known in the event they required this support.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to inadequate

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; 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; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

• The provider's quality assurance systems such as audits were not being operated effectively as demonstrated by a number of shortfalls identified during the inspection, which had not been identified by the provider so they could put things right. These included the quality of risk assessments for people using the service, shortfalls with the management of medicines, lack of person-centred care planning and provision and shortfalls around the level of engagement with people and provision of recreational activities for them.
• There was also a lack of clear vision about the service development, approach to quality and what needed to improve. We found in some cases there were no audits, for example of staff files, or these were ineffective such as the 'bed changing - cleaning audits' where shortfalls had not been identified so these could be addressed.
• People's files were reviewed when they were the 'resident of the day'. There was a lack of audit trail and clear recording about whether the processes around the resident of day initiative had been implemented. The name of the resident of the day was recorded on the handover form and we saw some records were blank, so it was not possible to determine who was the resident of the day or if their file had been reviewed.
• Incidents and accidents were not effectively investigated to identify causative factors to enable learning to take place to improve service delivery.
• After the inspection the manager explained a number of indicators and documents were reviewed in a weekly meeting held with managers from the provider's other locations. They advised areas such as incidents and accidents and quality assurance checks were discussed in their meeting as well as improvement actions. However, they did not provide us with any written evidence of analysis or actions taken to improve service delivery as the result of incidents, safeguarding alerts or complaints within the service.
• After the inspection the manager emailed us weight charts and a health and safety inspection schedule but without an analysis or action plan it was not clear what learning was taking place and what improvements were identified and addressed.

• Furthermore, we found that records were not always maintained in a complete and accurate way and were not always easily accessible. We had to wait for significant amounts of time for the manager to provide the requested documents, even though we had provided a written list to them at the beginning of the inspection. For example, we noted incidents and accidents did not have preventative plans in place. The manager said they did, so we asked them to show us. After looking for them, the manager came back and told us they could not find the record in the file, although they believed it had been completed.
•The manager explained they had systems for gathering feedback from and engaging with people using the service, relatives and staff. However, we did not see minutes, records and outcomes of meetings or feedback. This meant there was no systematic way of assessing the quality of people's experiences and involvement in the way the service was provided, and analysing their views to identify areas for improvement but also areas of strength, so the provider can build on these.
•The provider was aware when they needed to share information with other agencies including the local authority and CQC. However, we found they did not always do this in a timely manner. For example, the local authority raised a safeguarding alert with the provider in July 2021, but the provider did not submit a notification to CQC until about three weeks later.

The above shortfalls meant the provider did not have adequate oversight of the service and did not have effective quality assurance systems to monitor, assess and improve the quality of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•People and their relatives felt they could raise concerns. One relative said, "The [deputy] manager normally has a word with me when I arrive to tell me how [relative] has been doing."
•At the time of the inspection, the manager was planning to become the registered manager and the provider was recruiting a new deputy manager. People and their relatives gave positive feedback about the manager. Comments included, "Yes, I know the manager I can speak to her if I have a problem" and "Yes, I see the manager from time to time."
• Staff felt supported and there was good communication within the staff team through handovers.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• People and staff spoke positively about the management of the home. Staff told us they received the training, information and the support they required to carry out their roles.
• The provider had followed government guidance to support people's families visiting the home so they could be involved in their family members' care.

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 9 HSCA RA Regulations 2014 Person-centred care The provider did not always ensure that care was designed for people with a view to achieving service users' preferences and ensuring their needs were met. Regulation 9 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider did not always ensure service users were treated with dignity and respect. Regulation 10 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not always seek consent for care and treatment from the relevant person and did not demonstrate they always acted in accordance with the Mental Capacity Act 2005. Regulation 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment

	The provider had not always protected service users from abuse and improper treatment. Regulation 13 (1)
Regulated activity	**Regulation**
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had not always ensured that the premises and equipment used, were suitable for the purpose for which they were being used. Regulation 15 (1)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not always assessed or done all that was reasonably practicable to mitigate the risks to the safety of service users. The provider did not always ensure the proper and safe management of medicines. Regulation 12 (1)

The enforcement action we took:

Warning notice issued

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not ensure systems were operated effectively to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and to assess, monitor and improve the quality and safety of the service. Regulation 17 (1)

The enforcement action we took:

Warning notice issued.