St. Matthews Limited

Willow Brook House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Willow Brook House is a nursing home providing accommodation and personal care to up to 43 adults. The service is comprised of one building over two levels. At the time of inspection there were 36 people living at the service with severe, enduring mental illness with complex needs.

People's experience of using this service and what we found
People were not always safe as the provider had admitted people to the home without ensuring they could meet their needs and were compatible with people already living at the home. People were exposed to incidents of verbal and physical aggression.

There were not enough staff with the skills, competencies and experience to meet people's clinical and care needs.

People did not have all their risks assessed and staff did not have the information they needed to provide for their needs. Staff did not have all the information they needed to ensure people had the right texture of food and drink to prevent them from choking or aspirating.

People were at risk of undetected deterioration in their health, as staff did not always follow the provider's systems to monitor people's clinical observations. The provider failed to have a system to manage people's healthcare appointments or include outcomes of health appointments in people's care plans.

People did not always receive their prescribed medicines as they were out of stock. People who required time critical medicines were not receiving these on time to prevent unmanaged symptoms of their conditions.

People were not involved in their care planning or asked for their feedback about the service. The provider failed to ensure people's communication needs were met. People's and relatives' verbal complaints were not recorded or always responded to.

The provider failed to employ enough staff to manage, monitor and improve quality and safety of the service. The provider identified areas for improvement but did not have the resources or systems to implement and embed these into practice.

The provider's systems were ineffective in identifying and mitigating environmental or health and safety concerns.

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

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

Rating at last inspection
This is the first inspection since registering on 21 July 2022.

Why we inspected
The inspection was prompted in part due to concerns received about staffing levels and safeguarding concerns. A decision was made for us to inspect and examine those risks.

Enforcement
We have identified 7 breaches in relation to staffing, safe care and treatment, person-centred care, nutrition, consent to care, complaints, governance and leadership at this inspection.

Please see the action we have told the provider to take at the end of this report.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures:
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Willow Brook House

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was carried out by 2 inspectors, a specialist nurse 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
Willow Brook House is a 'care home.' People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Willow Brook House is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This 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 no manager registered with CQC. An application to register had been made by the existing 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. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 8 people and 3 relatives of people who used the service about their experience of the care provided. We spoke with 15 members of staff including 2 managers, 1 deputy manager, 1 nurse, 2 agency nurses, 5 agency care staff, 3 domestic staff and maintenance. We also spoke with the GP and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included 12 people's care records and multiple medication records. We looked at 4 staff files in relation to recruitment and 8 agency staff profiles. We reviewed a range of records including accident and incident records, audits and a variety of records relating to the management of the service, including policies.

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.

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

Staffing and recruitment

- There were not enough staff employed to meet the needs of people living at the service. There were a high number of vacancies for nursing and care staff. The provider continued to admit people with complex mental and physical health needs without the resources to manage their care or meet their needs. One relative told us they were worried for the safety of their relative, they said, "Other residents are fighting, there are no staff to intervene, there are no regular staff."
- The provider deployed large numbers of agency staff. Agency nurses were deployed every day. Staffing rotas showed for every 7 to 10 care agency staff deployed daily there were 0 to 2 permanent care staff. Of these agency staff, 39% of agency staff had provided care for only 1 or 2 days. This meant people were being cared for by staff that did not always know them or have the opportunity to provide continuous care. One person told us, "Sometimes there's enough staff other times there's not." Another person said, "Saturday and Sunday the lack of staff is a nightmare."
- The provider deployed staff to provide 1 to 1 continuous supervision (1:1 care) to people who had been identified as at risk to themselves and others through verbal and physical aggression. At the time of inspection there were 8 people who required 1:1 care. Seven of these were based in the Birch unit which we observed to be very noisy and crowded due to the numbers of staff closely supervising people, alongside other people using the service and staff. People were at risk of witnessing aggression and altercations due to the crowded and noisy environment.
- The provider had not employed key staff such as assistant psychologists or deployed occupational therapists to oversee daily care to provide for the needs of 14 people admitted for multi-disciplinary care (MDT).

The provider had failed to ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced staff to provide safe care. This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

- The provider was actively recruiting nurses, care staff and an assistant psychologist.
- The provider followed safe recruitment practices. They received references of previous employment and carried out Disclosure and Barring Service (DBS) checks which provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
- The provider checked agency staff had all the relevant pre-employment checks before working at the service.

Assessing risk, safety monitoring and management

● People did not have all their risks assessed or have care plans which provided staff with the information they needed to mitigate known risks. Before people were admitted to the service, people had been identified as at risk of falls, unsafe moving and handling and poor skin integrity, so these risks had not been assessed or mitigated. For example, one person had a body map showing they had multiple bruises, but they did not have a risk assessment or care plan to mitigate against further injury or monitoring.
● People were not always protected from the risks of scalding, choking or harm associated with the misuse of cleaning fluids as they had access to hot urns, kettles, powdered drinks thickener and cleaning liquids in the dining areas and false teeth cleaning tablets in bedrooms. The provider had not assessed the risks of people accessing these items which placed them at risk of harm.
● People were at increased risk of falls as they did not always have access to call bells. One relative described how their relative would fall as they tried to get out of their chair to get the attention of staff; they did not have a call bell. One person told us, "I have call bell, but it doesn't work, I've told them, but nothing happens."
● People were at risk of ill health as they were receiving dairy products that had stored at too high a temperature. The provider had purchased a new fridge, but failed to ensure it was keeping food at the required temperature.

Using medicines safely
● People did not receive all their prescribed medicines. Between 9 April and 6 May 2023 15 people had missed 167 doses of their prescribed medicine as staff had recorded these medicines were not available as they were out of stock. This included medicines for the treatment of psychosis, depression, heart conditions, epilepsy, and pain. People were at risk of deteriorating health or uncontrolled symptoms of their conditions as they were not receiving their medicines as prescribed.
● People were at risk of not receiving their prescribed medicines at the times they were prescribed as the morning medicines rounds took over 4 hours. We observed each person required time due to the complex nature of their needs. This meant there was a risk that medicines that were due in the morning and lunch time were given too close together, or doses missed as they could not be given as not enough time had elapsed between doses. This placed people at risk of deteriorating health or increased symptoms such as pain as they were not receiving their medicines as prescribed.
● People who were living with Parkinson's disease did not always receive their time critical medicines on time. Medicines records showed people required their dose 3 hourly during the day to control their symptoms, did not receive their medicines at regular intervals, or on time. One relative told us, "Often I leave at 4.30pm and staff haven't given [person] their [time critical] medicine (which is due) at 4.00pm. This has happened 3 times in the last 4 weeks." This placed people living with Parkinson's disease at risk of experiencing increased and unmanaged symptoms of their condition.

The provider had failed to ensure risks to people's health and safety had been assessed and done all that is practical to mitigate those risks. The provider had failed to ensure the proper and safe management of medicines. These are a breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

● During the inspection the provider arranged for locks to be placed on the cupboard doors in the dining areas to store the cleaning fluids and powdered drinks thickener. They also arranged for a locked cabinet to be built around the hot urns to reduce access to these and reduce the risk of scalding.
● After the inspection the provider reviewed all the risk assessments and care plans and had an action plan to complete these reviews.
● The provider recognised the morning medicines round took too long; they had asked the GP to review people's medicines to see if some medicines could be administered at a different time of day.

● The provider planned to allocate two members of staff to administer the morning medicines in each unit to ensure people's medicines could be administered in a timely way, however, the staff had not been recruited.

Systems and processes to safeguard people from the risk of abuse
● The provider had safeguarding policies and procedures which had been followed. The provider employed a safeguarding lead who had oversight of the implementation of the policy and carried out regular reviews of practice.
● The provider had reported safeguarding concerns and complied with any investigations or reports requested by the local authority safeguarding team.
●Staff were aware of their responsibilities and knew how to raise concerns. However, not all staff had received safeguarding training. The provider had a programme of training for staff to attend safeguarding training which was on-going.

Learning lessons when things go wrong
● Accidents and incidents were recorded, analysed and learning identified. However, the learning could not always be implemented due to management and staff capacity.
● The provider had implemented further fire safety procedures as a result of learning from an incident at another of their locations.
● The provider issued newsletters to staff to share the learning across the organisation.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● The provider followed government COVID-19 guidance on care home visiting. Visitors were welcomed into the home.

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.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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 failed to provide care and treatment in accordance with the requirements of the MCA.
- The provider had not assessed whether 8 people who were subject to daily 1:1 continuous observation had the mental capacity to understand and consent to the 1:1 care. There were no records of a best interest meeting to discuss the impact of continuous observations, or to discuss if the continuous observation was the least restrictive action to keep people safe. This put people's right to privacy at risk.
- The provider had made applications to legally authorise people to be deprived of their liberty but had failed to carry out the necessary mental capacity assessments or best interest meetings regarding living at the service, consent to care or medicines. This meant people were at risk of being deprived of their liberty without the safeguards being in place in accordance with the MCA.

The provider had failed to ensure care and treatment was provided with the consent of the relevant person. This is a breach of regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent.

Supporting people to live healthier lives, access healthcare services and support; Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- People were at risk of deteriorating health conditions. Staff did not consistently record people's clinical

observations when people became unwell. Records of actions taken when people's observations were outside of their 'normal range' where not always in place. This meant people were at risk of undetected deterioration in their health and delay in medical care.

● People were at risk of not receiving prescribed care or attending health appointments. During the inspection we found unopened letters regarding people's health appointments. Two relatives told us they had concerns as they had not been kept informed of health appointments and actions prescribed at health appointments had not been implemented. One relative said, "They don't keep me aware of letters [Name] receives from the hospital regarding appointments. There was a letter recently about a [medical] appointment which I didn't know about. We didn't even know he had a [medical] problem."

● People's needs had been assessed before admission. However, the provider failed to assess if people would be compatible with people already living at the service or have enough experienced staff to meet their needs. This had resulted in 8 people requiring 1:1 care to help protect them from each other in an environment which was noisy and crowded. One person told us, "People bang on my door at night it makes me worried. I do lock the door so they can't come in. I would like them to stop that happening."

● The provider failed to ensure people's risks had been assessed on admission. The care planning system included evidence-based tools which could have provided detailed information for staff to refer to, but these were not used. For example, Waterlow, a tool to assess skin integrity. Staff did not always have the information regarding people's risks of pressure ulcers, falls, moving and handling and nutrition to provide care to meet their needs.

The provider had failed to ensure risks to people's health and safety had been assessed and done all that is practical to mitigate those risks. This is a breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

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

● People were at risk of choking. Care plans were not always reflective of people's current needs relating to modified food and fluids. One person's food and fluid charts showed staff regularly gave them the wrong texture of food, placing them at increased risk of aspiration and choking due to staff not providing food and drink as prescribed by healthcare professionals.

● People were at risk of dehydration and there was a lack of oversight of people's fluid intake. Staff recorded what people drank, but the total amount of drinks per day did not meet their daily target which had been set to meet their needs. We observed people did not always have access to adequate fluids. For example, we observed 1 person was given a jug of juice but no glass to drink from. One relative told us, "[Person] often has no drinks."

● The provider did not routinely complete the assessments required to identify people's individual risks of dehydration or malnutrition. One person's care plan stated they required a Malnutrition Universal Screening Tool (MUST) completed and reviewed monthly. However, there was no MUST completed for that person. [MUST is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition or obese. It also includes management guidelines which can be used to develop a care plan].

● People living with diabetes were not offered alternatives to puddings with sugar in. One person told us, "I'm diabetic type 2, they offer me sweets I shouldn't have." People living with diabetes were at risk of unstable blood sugars.

● People told us the food was not good and the choices were limited. One person said, "The food used to be good, but it's gone downhill. You only get a choice of non-vegetarian or vegetarian." Another person said, "The food is terrible. They don't give me a choice they just put it down. I'd like a menu but never had one."

The provider had failed to ensure the nutritional and hydration needs of people were met. This is a breach of regulation 14 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Meeting

nutritional and hydration needs.

Staff support: induction, training, skills and experience
● There were not always sufficient staff with the necessary skills, knowledge or experience to meet people's needs.
● The provider did not have sufficient assurances that agency staff had the skills, knowledge and experience required to meet people's needs. The agency records showed they had received all of their training over two days, including training which would normally be carried out over a longer period of time. There was no system of supervision to ensure agency staff had the skills, competencies and support to provide safe care.
● Permanent staff had not always had the required training to keep people safe from harm. The training records showed staff did not always have up to date, valid training in areas such as safeguarding, moving and handling, challenging behaviour, PAMOVA (prevention, assessment and management of violence and aggression), food safety, dementia and communication. One person told us, "Some of them know what they are doing. The temporary ones are not so good."
● Staff did not always have the training, knowledge or skills to meet people's health needs. Not all staff had training on epilepsy or diabetes which placed people living with these conditions at risk of undetected deterioration, or the risk of staff not knowing how to recognise or respond to an emergency situation.

The provider had failed to ensure staff were competent to provide safe and effective care. This is a breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

● New staff attended the provider's induction and received supervision.
● The provider had identified in their April 2023 audit, that staff did not attend training due the location of the training. The provider told us they were looking at reviewing the venue for the training and/or providing transport for staff to attend the training.

Adapting service, design, decoration to meet people's needs
● The home had been adapted to meet people's mobility needs.
● People's room reflected their personalities and contained personal items.

Requires Improvement

Is the service caring?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- People had not been involved in planning their care. People did not always have care plans to manage their health conditions or mitigate their risks. People told us, "I've had no care plan discussions yet," "I've never heard of a care plan" and "I don't think I have one [care plan]." A relative told us, "I have mentioned [name's] care plan but am still waiting."
- The provider had sought people's feedback in March 2023, but action had not been taken to resolve the issues raised. One person had told the provider, "It can get very noisy and violent with a lot of commotion and that depresses me." This issue had not been resolved as we continued to observe the home to be crowded and noisy with many incidents of verbal and physical aggression.
- People did not always get the response they needed from staff. One person living in the Birch Unit said, "Occasionally I ring my bell to help get me up. I can wait minutes or an hour sometimes. They come in and cancel my call and don't come back." We observed staff did not always interact with people when they were providing care.
- People did not always have the opportunity to engage with staff. The service relied on high numbers of agency staff who were not familiar with people using the service. There was insufficient recognition of the communication needs or preferences of people by the provider, with a lack of support offered to staff to meet these. We observed one person trying to tell staff how they felt, but staff struggled to understand as the person was expressing themselves using informal language in a strong London accent. Staff were not familiar with the terms being used, as they had not been offered support by the provider to do so. The person was showing signs of distress and shouting to try and make themselves understood.
- The provider failed to ensure people had access to the right time. There had been many clocks installed at the service in communal areas, but none of them had been activated. We observed all the clocks were set to 12 o'clock; the time did not change throughout the day. People could be disorientated in time, and not be able to plan their time especially those people living with dementia.

The provider failed to carry out, collaboratively with the relevant person, an assessment of the needs and preferences. This is a breach of regulation 9 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care.

Respecting and promoting people's privacy, dignity and independence; Ensuring people are well treated and supported; respecting equality and diversity

- People living in the Rowan Unit told us staff were kind, caring and attentive. People told us, "I think the staff do a great job, they come and talk to you, they have time to listen" "The staff look after me, quite kind,

no bad experiences" and "The staff are very helpful."

● People told us they were encouraged to maintain their independence. People told us, "I dress myself; I get up when I like. There are no restrictions on going to bed" and "I can get out of bed and into my chair, I only need help with bathing. I can have a bath when I want. I managed to shower on my own for the first time yesterday."

Inadequate

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Support to follow interests and to take part in activities that are socially and culturally relevant to them

- People were not receiving their commissioned care. Since January 2023 14 people had been admitted for multi-disciplinary care (MDT) which included psychotherapy and occupational therapy. Staff did not have information about the specific care people should receive to manage their psychological needs. Not all people had been assessed by an occupational therapist. The weekly oversight by a psychiatrist and psychotherapist was not incorporated into handovers or in care plans. People were not receiving their commissioned care.
- The provider had admitted people from hospital, to assess them for discharge to suitable care. These people had not had all of their risks or needs assessed, or care plans created to ensure staff knew how to manage their needs. People were at risk of being discharged to other services, or home without a complete assessment of their needs.
- People's care plans did not reflect their needs and preferences as they were incomplete and did not reflect them as a person. Staff did not always have the information they required to meet people's current needs. One person told us, "I have not been asked about my likes and dislikes."
- People were not always supported to engage and partake in activities. Staff employed to support and promote engagement had been redeployed as care staff. People told us, "(There are) no activities at all" and "It's not that bad here it's just mundane and boring because of the mix of people here. Improving that would help." A member of staff told us, "We don't really have any activities, we should really. I try and take them out for fifteen minutes to get some fresh air and go to the shops."

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.

- Staff did not always have the knowledge to support people with their communication needs. One person's admission record showed they used a form of Makaton to communicate. None of the staff had received training in Makaton or been shown what the person required to communicate. There was a risk this person could be isolated due to the lack of effective communication.
- The provider had not made provision for people to communicate their feedback where they were unable to write their responses. The provider had a survey to gain people's feedback but did not have a system for

people to provide the feedback verbally and independently of staff.
● The provider failed to make provision to assist staff to engage with people or to understand informal terms or phrases people used. Guidance in people's care plans was limited and staff were not offered support or training to assist in their communication with people. One person told us, "I can't understand [staff] sometimes." This issue had not been identified and addressed through the provider's own monitoring and feedback processes.

The provider had failed to ensure people received care that met their needs and reflected their preferences. This is a breach of regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care

● People had hobbies and could pursue these. For example, one person told us, "'I have a railway track in my room and some trains in the drawer it's a hobby of mine." Another person said, "I have my [computer tablet] and my phone that does me." Where people were able, they went into the garden and occasionally staff took people out for a walk. Two people told us they made regular visits to the pub together with staff.

Improving care quality in response to complaints or concerns
● People's verbal complaints had not been responded to. People and relatives told us they had made complaints about their call bells not working, the lack of care plans, not being informed of hospital letters and the front door not being answered. Not all of these issues had been resolved or prevented in reoccurring. These complaints were not logged or formally responded to as the manager told us these had been made verbally and would be resolved locally.
● The provider had a complaints policy and procedure. However, not all people had been made aware. One person told us, "I haven't any concerns, I don't know who I'd tell if I did." One relative told us, "There was no mention of a complaints procedure." Some people told us they had not needed to make a complaint.

The provider had failed to identify, record, handle and respond to all complaints. This is a breach of regulation 16(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Receiving and acting on complaints.

● The provider had responded to written complaints in line with their procedure. For one relative who had made complaints; the manager had held regular meetings with them to keep them informed and help them to adjust to their relative living at the home.

Supporting people to develop and maintain relationships to avoid social isolation
● People were supported to stay in contact with significant people. One person told us, "'I have visitors my family come, it seems quite flexible."
● Relatives were able to visit freely. However, relatives told us they often struggled to enter the building as staff were not available to answer the door, especially in the evenings and weekends. One person told us, "At weekends I can wait twenty minutes before they let us in. There is no-one on reception it happens regularly." We observed on the day of inspection that the post person waited for over 15 minutes to be let into the service to deliver their post.

End of life care and support
● People did not have care plans that reflected their wishes and preferences towards the end of their lives.
● Where people had received end of life care, the GP had been involved to provide assessment of needs and prescribed medicines to manage people's symptoms.
● The manager had considered people's cultural needs. For example, by contacting people's local church to

provide pastoral 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.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- The provider failed to have effective systems in place to ensure they had adequately assessed new people's needs and the needs of those already living at the service to ensure people were compatible to live together. The provider's commissioning team had not taken the managers' concerns into consideration before authorising admissions to the service. This put people at risk of poor outcomes and people and staff being subject to verbal and physical aggression.
- The provider failed to have a system to ensure they had the resources to meet people's needs. The provider continued to admit people to the service knowing they had not employed enough staff to meet people's needs. There were insufficient checks of agency staff skills, competencies, or supervision to ensure all staff had the knowledge and skills they required to meet people's needs. Agency staff did not have named logins for the care records; there was a risk that incidents and complaints could not be investigated due to the lack of signed records.

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

- The provider failed to have systems in place to assess whether the service had the management structure and key staff to monitor the quality and safety of the home and make all the required improvements. One person told us, "So many things are inefficient here."
- The lack of systems to identify and rectify when mental capacity assessments and best interest decisions were not completed meant people were at risk of having their liberty deprived or receiving care without giving consent.
- The provider failed to have systems in place to ensure all people had their risks assessed and staff had the information to mitigate the risks in the form of care plans, or to have care plans that reflected people's current needs. This risk was further heightened by the large numbers of agency staff who were not familiar with people's needs. People were at risk of receiving care that did not meet their needs.
- The provider failed to have systems for managing people's healthcare appointments or include outcomes of health appointments to people's current care plans. People were placed at risk of undetected deterioration of their health as the provider failed to have systems to check staff were following the procedures for monitoring clinical observations and responding appropriately.
- The provider failed to have sufficient systems to manage people's medicines safely. People did not receive all of their prescribed medicines, or time critical medicines on time to manage their health conditions.
- Systems and processes were ineffective in identifying and mitigating environmental or health and safety

concerns. People were placed at risk of harm from accessing cleaning materials, hot water and from food that had not been stored safely. The provider's audit on 19 April 2023 had identified these issues, but they failed to take action to protect people from harm.

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

- The provider had a system to gain people's feedback; they had received one response. However, all the people and relatives we spoke with told us they had not been asked for their feedback.
- The provider did not ensure people had the opportunity to meet as a group to discuss the quality of the care at the home as there had not been any residents' or relatives' meetings. One person told us, "There's no such things as residents' meetings." A relative told us, "The last newsletter was on the 2nd December (2022) nothing since."

The provider failed to ensure adequate systems and processes were in place to assess, monitor and improve the quality and safety of the care provided. This was a breach of Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

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; Continuous learning and improving care; Working in partnership with others

- The provider's quality monitoring in April 2023 had identified where they had failed to report 2 incidents to safeguarding. The actions from the audit had rectified this and systems put in place to closely monitor future incidents.
- The provider' safety review in April 2023 found staff actions following falls required updating to include information about people's health 72 hours following a fall. This had been implemented and was in the process of being embedded.
- The new manager understood their responsibilities to inform people and their relatives when things went wrong.

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
Treatment of disease, disorder or injury	The provider failed to carry out, collaboratively with the relevant person, an assessment of the needs and preferences. The provider had failed to ensure people received care that met their needs and reflected their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints
Treatment of disease, disorder or injury	The provider had failed to identify, record, handle and respond to all complaints.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider failed to ensure adequate systems and processes were in place to assess, monitor and improve the quality and safety of the care provided.

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 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The provider had failed to ensure care and treatment was provided with the consent of the relevant person.

The enforcement action we took:

We issued a Warning Notice to the provider to state they must be compliant with Regulation 11, Consent to care by 31 May 2023.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider had failed to ensure risks to people's health and safety had been assessed and done all that is practical to mitigate those risks. The provider had failed to ensure the proper and safe management of medicines.

The enforcement action we took:

We issued a Warning Notice to the provider to state must be compliant with Regulation 12, Safe Care and Treatment by 30 June 2023.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs
Treatment of disease, disorder or injury	The provider had failed to ensure the nutritional and hydration needs of people were met.

The enforcement action we took:

We issued a Warning Notice to the provider stating they must be compliant with Regulation 14, Meeting nutritional and hydration needs by 31 May 2023.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Treatment of disease, disorder or injury	The provider had failed to ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced staff to

provide safe care. The provider had failed to ensure staff were competent to provide safe and effective care.

The enforcement action we took:

We issued a Warning Notice to the provider to state they must be compliant with Regulation 18, Staffing by 30 June 2023.