D & J S Barnfield

Bancroft Gardens Residential Home

Inspection report

Waterside
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Bancroft Gardens Residential Home is a residential care home providing accommodation and personal care to up to 16 people. At the time of our inspection there were 15 people using the service. Some of these people were living with dementia. The care home is situated in the centre of Stratford-Upon-Avon, overlooking the river.

People's experience of using this service and what we found
Risk's related to people's health were not always identified, assessed or managed. Some people had recently lost weight. Records did not always evidence timely action had been taken to mitigate the risk of further weight loss.

Environmental risks were not always managed safely. There was an increased risk of falls from heights as bedrooms on the second floor either did not have a window restrictor or had a window restrictor that did not meet Health and Safety Executive standards. People could access the flat rooftop on the second floor as the key had been left in the lock. The security of the building was also compromised.

Fire risks were not always managed safely. An external agency had identified significant fire safety risks prior to our inspection. No action had been taken to reduce the identified risks.

Medicines were not always managed safely. Medicines were left unattended in the communal dining room on both days of our inspection and some medicines were not administered in line with best practice. Some people were prescribed medicines on an 'as required' to treat a short term or intermittent medical condition such as pain or anxiety. Some of these medicines were being administered by staff daily as a regular dose without an appropriate rationale.

There were enough staff to meet the providers assessed safe staffing numbers. However, the provider had experienced difficulties recruiting staff and as a result, staffing numbers were maintained by using temporary staff supplied through an agency. Relatives expressed concerns about the numbers of staff on shift. Required pre-employment checks had not always been completed. For example, one person was working without a valid Disclosure and Barring Service (DBS) check.

Some people did not receive care in a timely way because they were unable to summon assistance when care was needed. At various points throughout our inspection, people were calling out to receive care because they had been left without their call bell.

The quality of care provided to people at Bancroft Gardens Residential Home was inconsistent and we received mixed views from people and relatives. Some shared good experiences, whilst others did not. Whilst we saw some caring interactions between staff and people, staff had limited time to spend with people to enhance their well-being or to ensure effective communication. Some people commented staff

did not always treat them with respect. People did not wish to elaborate on why they felt this way.

Basic assessments were in place to assess people's mental capacity. However, these assessments were not decision specific and did not evidence how people had been supported and empowered to make specific decisions. People were not always supported to have maximum choice and control of their lives and staff did not always support people in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Infection control procedures were not always effective. Staff did not consistently follow current guidance when using personal protective equipment. There were limited risk management strategies to prevent infections entering the home. The home was clean, but there was no sluice facility available for disposal of clinical or bodily fluid waste. Bed rail covers were split and damaged which meant they could not be cleaned effectively. Some relatives told us there were often unpleasant odours when they visited.

The provider had not maintained effective oversight to ensure people received high quality care in a safe environment. We found widespread concerns in areas such as environmental risk management, risks to people's health, medicines management, infection control, recruitment, mental capacity, accident and incident management and nutrition. Relatives recognised the commitment of the registered manager, but some did not feel the home continued to be well managed. Some relatives felt emotional responses from the registered manager prevented them from raising concerns.

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 7 July 2018).

Why we inspected
The inspection was prompted in part due to concerns received about staffing, risk management and governance. A decision was made for us to inspect and examine those risks. 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 improvement. The overall rating for the service is now inadequate based on the findings at this inspection.

You can see what action we have asked the provider to take at the end 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 have identified breaches in relation to safe care and treatment, the premises, nutrition and governance at this inspection.

We met with the provider and the local authority following our inspection. The provider confirmed their intention to voluntarily close Bancroft Gardens Residential Home and cancel their registration. We will

continue to monitor this closure and will take further action if needed.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety prior to the home closure. We will work alongside the provider and local authority to monitor progress of the home closure.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Bancroft Gardens Residential Home

Detailed findings

Background to this inspection

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

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

Inspection team
Two inspectors and an Expert by Experience completed this inspection. 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
Bancroft Gardens Residential Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Bancroft Gardens Residential Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

At the time of our inspection there was a registered manager in post.

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, Healthwatch and other professionals who work with the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make.

We used all this information to plan our inspection.

During the inspection
We spoke with five people and eleven relatives about their experience of the care provided. We spoke with eight members of staff including three care workers, one senior care worker, the cook, the deputy manager and both partners from the provider. One of the partners was the registered manager. We also received feedback via email from one care worker.

We spoke to three healthcare professionals about their experience of the clinical care provided. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included multiple people's care and medicine records. We looked at three staff files in relation to recruitment. A variety of records relating to the management of the service were also reviewed.

Inadequate

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management; Using medicines safely

- Risks related to people's health were not always identified, assessed or managed. On the first day of our inspection, one person's catheter bag had been placed in a container on the floor rather than on a recommended catheter stand. As a result, fluid was unable to flow easily into the catheter bag and had started to backtrack along the tube which posed risks to the person's health. By the second day of our inspection, action had been taken and a catheter stand was used to allow effective drainage.
- There was limited oversight of other risks related to catheter care. For example, the provider was not using risk management tools such as fluid monitoring charts to ensure people were drinking and passing enough fluids. Whilst some of this information had been recorded in daily records, this was not monitored to identify any indicators of deterioration in health. By the second day of our inspection, fluid charts had been implemented but these were not consistently completed so oversight could be effectively maintained.
- Some people had been assessed as 'high risk' of skin breakdown. One person needed to be repositioned in bed to relieve pressure on vulnerable areas of their body. There was no information about how often this needed to be done or what equipment should be used to ensure the person's skin integrity was maintained. On the second day of our inspection, repositioning charts had been implemented, but there was still no information as to how often people needed to be repositioned or the equipment required.
- Moving and handling equipment was used without the appropriate authority or assessment. On the first day of our inspection, two staff used a moving and handling belt to lift a person from their chair. Records did not show this had been agreed as an appropriate intervention for this person. The deputy manager confirmed this practice had put the person at potential risk of harm.
- Medicines were not always managed safely. On the first day of our inspection, medicines had been left unattended in the dining room. This posed a risk as other people could have taken medicines not prescribed for them. Despite assurance from the registered manager this was an isolated mistake, on the second day of our inspection medicines for two people had again been left unattended in the dining room.
- Prescribed creams and ointments were stored in the food pantry, which was not locked, or temperature controlled. Excess medicine stock was stored in the office which was also not temperature controlled. Providers must ensure medicines are stored in line with the manufacturer's instructions, which for some medicines, includes being stored below 25 degrees to ensure they remain effective. Where the temperature of the main medicine cabinet was recorded and exceeded 25 degrees, it was not clear what action was taken to ensure the medicines remained effective.
- Some people living at the home were prescribed medicines on an 'as required' basis which are usually prescribed to treat a short term or intermittent medical condition such as pain or anxiety. Two people had been prescribed a medicine to relieve short term anxiety on an 'as required' basis, but there was no information to inform staff when these medicines should be administered. These medicines were being administered by staff daily, as a regular dose with no supporting evidence of any anxiety being displayed.

The provider had not ensured risks related to the health and safety of people using the service had been identified and assessed or done all that was reasonably practicable to mitigate such risks. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following our inspection, the registered manager took action to ensure the safe storage of creams, ointments and excess medicine stock. They also arranged for an urgent medication review.
● Environmental risks were not always managed safely. For example, there was an increased risk of falls from heights which posed a risk of significant harm. Bedrooms on the second floor either did not have a window restrictor or had a window restrictor that did not meet Health and Safety Executive standards. People could access the flat rooftop on the second floor as the key had been left in the lock. The provider took immediate action after our feedback and removed the key and arranged for a more suitable lock to be fitted. They also arranged for safe window restrictors to be fitted.
● At our last inspection, we found fire safety practices needed improvement. At this inspection, further concerns were found. On 3 August 2022, a fire safety risk assessment had been completed by an external organisation which identified a 'substantial risk rating' requiring urgent action. A report containing these findings was received by the provider on 11th August 2022, six days prior to out visit. At the time of our visit, no action had been taken to reduce the identified risks.
● One bedroom door continued to be propped open with a wedge and another bedroom door had a large gap underneath which meant they would not be effective in containing the spread of fire. Another bedroom had an open hatch which led into a loft space which contained a large amount of combustible material, and other fire doors were left open without suitable fire safety closures. Electrical extension cables were also strung together which increased the risk of fire. We reported our fire safety concerns to Warwickshire Fire and Rescue Service.
● There was limited assurance about the safety of people due to insufficient security at the home. On the first day of our inspection, a relative of a temporary worker supplied via an agency, was found asleep in the front lounge by our inspection team. They had been in the premises for three hours without the appropriate authority or knowledge of the registered manager. On the second day of our inspection, we were let into the home by an ex-employee who still had full access to the home. This posed a risk because the provider had not completed any recent safety checks.

The provider had not ensured the premises, where care and treatment was being delivered, were safe and secure. This placed people at risk of harm. This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Records showed there were enough staff to meet the providers assessed safe staffing numbers. However, the provider had experienced difficulties recruiting staff and as a result, staffing numbers were maintained by using temporary staff supplied through an agency.
● Relatives raised concerns about the numbers of staff on shift. One relative told us, "I am still concerned, the level of staff is bad. [Registered Manager] is the linchpin and when she is not there, it all goes wrong." Another relative commented, "They always seem short staffed. There are not always enough staff to do things when [person] needs it."
● Required pre-employment checks had not always been completed. For example, one person was working without a valid Disclosure and Barring Service (DBS) check. DBS checks provide information about convictions and cautions held on the Police National Computer. This information helps employers make safe recruitment decisions. Gaps in staff employment histories had also not been explored. The provider took immediate action to gain the appropriate recruitment checks for this staff member following our visit.

Systems and processes to safeguard people from the risk of abuse

● Some people did not always feel safe from the risk of abuse. Comments included, "Some staff are nice, and some are not. I try and avoid them" and, "Some staff don't like me, but I won't say any more than that." People did not wish to elaborate on why they felt this way.

● We received mixed feedback from relatives about whether they felt people were safe. Some relatives shared worries about the quality of care provided, where others reported a more positive experience.

● Staff understood their safeguarding responsibilities; however, they did not always know how to escalate concerns outside their organisation. One staff member told us, "I've only ever reported things to my manager. So not sure what I would do or who to tell if they weren't here".

Preventing and controlling infection

● We were not assured the provider was using personal protective equipment (PPE) effectively and safely. Staff did not consistently follow current guidance when using PPE. Whilst PPE was available within the home, we saw numerous occasions when staff wore their masks under their nose or chin whilst delivering care and whilst supporting people in communal areas.

● We were not assured the provider was preventing visitors from catching and spreading infections. There were limited risk management strategies to prevent infections entering the home.

● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. The home was clean, but there was no sluice facility available for disposal of clinical or bodily fluid waste. Covers on bed rails were split and damaged which meant they could not be cleaned effectively. Some relatives told us there were often unpleasant odours when they visited.

● We were somewhat assured that the provider was making sure infection outbreaks could be effectively prevented or managed. However, staff practice indicated they did not always follow their infection control training.

● We were assured that the provider's infection prevention and control policy was up to date.

● 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 responding effectively to risks and signs of infection.

Visiting in care homes

● There were no restrictions on visiting and their relatives and friends could visit whenever they wanted.

Learning lessons when things go wrong

● Accident and incident forms did not record any investigations undertaken to identify any cause of the accidents or incidents or any action taken to reduce the risk of reoccurrence.

●There was no overall analysis of accidents and incidents to identify any trends or patterns. Whilst the deputy manager assured us the level of accidents and incidents was very low, and explained actions were taken to keep people safe, this was not always reflected in the records.

Inadequate

Is the service effective?

Our findings

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

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

Supporting people to eat and drink enough to maintain a balanced diet; Supporting people to live healthier lives, access healthcare services and support

- People had recently lost weight. One person had lost 13.7kg within a four-month period. Another person had lost 8.2kg, and another person had lost 4.1kg in a similar time period. Whilst some weight-loss may have been explained by people's health complications, errors in nutritional assessments meant risks of malnutrition were not identified in a timely way.
- Records did not always evidence timely action had been taken to mitigate the risk of further weight loss. For example, food charts were not kept to actively monitor if people were eating enough, and referrals had not always been made to seek specialist support when needed. Where referrals had been made, these were not always followed up and actively reviewed as people's weight declined.

The provider had not taken enough action to reduce the risks of malnutrition. This was a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We shared our concerns with other stakeholders. As a result of our feedback, the provider sought urgent support from a dietician to ensure people's risk of malnutrition was identified, assessed, monitored and managed safely.
- We received mixed feedback about the quantity and quality of the food provided at Bancroft Gardens Residential Home. One relative commented, "The evening provision is not sufficient. Imagine half a sandwich cut again and that's it." Whilst another relative commented, "I am also very impressed with the standard of the meals. I don't think they could be bettered."
- The cook told us people could have an alternative option if they did not like what had been cooked, but this was not always evidenced in people's records. People gave positive feedback about the food. Comments included, "They feed us very well here" and, "There is plenty, more than enough for me."

Staff working with other agencies to provide consistent, effective, timely care

- Some people did not receive care in a timely way because they were unable to summon assistance when care was needed and there was limited evidence of regular welfare checks. For example, at various points throughout our inspection, people were calling out to receive care because they had not been left with access to their call bell. One person was calling out because they were cold. We found their call bell behind the television on their chest of drawers. Another person was calling out because they were thirsty and in pain, but their call bell was hooked over a socket. A healthcare professional and a relative also provided feedback of witnessing similar instances.

● Records showed people had access to general healthcare services when these were required. For example, people had been visited by the GP, optician and dentist. Where accidents had occurred, emergency medical assistance was sought.

Staff support: induction, training, skills and experience
● Staff received an induction when they started working at the home. This included working alongside more experienced members of staff which enabled newer staff to learn people's individual routines.
● Most staff had completed the provider's training programme to ensure they could meet people's needs. However, during the inspection we identified several concerns with staff practice in relation to infection control, risk management and medicine management which indicated their training was not always effective.
● The cook had not received training on The International Dysphagia Diet Standardisation Initiative (IDDSI) which is a global standard to describe the texture of foods and thickened liquids used for individuals with dysphagia. This posed a risk that food may not be presented in an appropriate form. The cook told us when a person required a pureed diet, all vegetables were blended together. This is not in line with best practice which recommends each food is pureed separately so it looks appetising and keeps its own colour and flavour.
● Staff told us they felt supported in their role and had regular opportunities to discuss their role with the registered manager.

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.

● Basic assessments were in place to assess people's mental capacity. However, these assessments were not decision specific and did not evidence how people had been supported and empowered to make specific decisions.
● Where the registered manager thought people lacked capacity to make important decisions, records did not always show decisions had been made in a person's best interests or that these decisions were the least restrictive option. For example, the use of bed rails or the use of 'when required' medicine being administered daily.
● Despite this, if the registered manager believed there were restrictions in people's care, they had applied for the legal authorisation to deprive a person of their liberty.

Adapting service, design, decoration to meet people's needs
● Bancroft Gardens Residential Home is an old building with some physical limitations. For example, the shower room was used to store items such as laundry baskets when not in use due to a lack of storage

space.
● The layout of the home was not designed or adapted to aid people's orientation or independence to move around the home without support. The living accommodation is accessed via a staircase or lift which presented challenges for some less mobile people, as they were reliant on the lift working to exit the building.
● Some areas of the home were very tired and in need of maintenance. For example, in one person's bedroom the window would not close securely.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● An assessment was completed before people moved into the home to ensure the provider could meet people's individual needs and preferences.
● However, as the provider was using a combination of paper and electronic records, it was sometimes unclear which was the most up to date assessment of a person's needs. For example, there were some detailed risk assessments in relation to some health conditions such as diabetes, but this detailed information had not always been transferred into the care plan

Requires Improvement

Is the service caring?

Our findings

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

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

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

- The quality of care provided to people at Bancroft Gardens Residential Home was inconsistent and we received mixed opinions from people and relatives. Some shared good experiences, whilst others did not.
- Some relatives commented on the caring nature staff and used words such as, 'loving' and 'kind'. Other relatives felt staff lacked compassion and gave examples of poor care practices.
- Whilst we saw some caring interactions between staff and people, staff had limited time to spend with people to enhance their well-being or to ensure effective communication. For example, one person became upset after a visit from their relative, but staff did not have time to sit with the person to offer reassurance.
- Due to a language barrier, another person could not understand what a staff member was asking them to do. Staff did not try to communicate in another way to ensure the person understood what was being asked.

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

- There was a lack of evidence to show how people had been supported to express their views or be involved in decisions about their care. Where appropriate, relatives did not always feel involved in peoples care plans.
- Despite this, staff understood the importance of involving people in day to day decisions such as what people wanted to wear or how people wanted to spend their time.

Respecting and promoting people's privacy, dignity and independence

- Records contained information on what people could do for themselves and how staff could encourage people to be independent. For example, one person had a special adapted fork which enabled them to eat independently.
- Although overall we saw staff respect people's privacy within their care interventions, some personal information was not always managed securely. For example, people's medication charts were left accessible to others in the dining room.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed 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

- Whilst some relatives told us staff and managers knew their family member well, staff did not always have time to spend with people to enhance their well-being.
- The provider was in the process of developing their care plans and had transferred some to an electronic care planning system while others were still on paper. In either form, care plans were not always updated to reflect people's current needs.
- Although some care plans contained person-centred information, some improvements were needed. For example, care plans did not always include people's goals and aspirations, and how staff could support people to achieve these.
- It was not always clear how changes in people's care needs were communicated to staff to ensure they remained up to date with the latest information. Staff had access to the care plans via a hand-held device but did not always have time to read these.

Meeting people's communication needs

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

- People's care plans included some information about their communication needs in relation to vision, hearing and speech.

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

- Staff did not always have time to support people to follow their interests or encourage them to take part in social activities. During both days of our visits, there were no planned activities and records did not demonstrate many activities had been encouraged prior to our visit. One person asked, "Is there anything on this afternoon" and a staff member replied, "No".
- Relatives told us improvements were needed to support people's emotional well-being. Comments included, "I think the interaction could be improved. The activity lady isn't there and so [person] doesn't get the interaction." Another relative told us, "There is no interaction, stimulation or outings."
- The registered manager told us, "We admit it has been difficult with the multiple changes in visitor policy to keep an active social programme going, as was very present prior to the pandemic." They explained they had taken some action. A large interactive iPad to encourage sensory games had been purchased and an

external fitness instructor visited once a week.
● People were encouraged to maintain relationships with people important to them and relatives could visit whenever they wished.

Improving care quality in response to complaints or concerns
● A complaints policy was in place, however we received mixed feedback from relatives about whether they felt confident to raise concerns and complaints.
● Some relatives told us they had tried to raise concerns with the registered manager but had found this difficult because the registered manager had taken criticism too personally.

End of life care and support
● Staff had received training in caring for people at the end of their life. The registered manager worked with medical professionals to ensure people had a pain free and dignified death.
● Where necessary, Do Not Attempt Resuscitation (DNAR) forms were in place to tell medical professionals when not to attempt cardiopulmonary resuscitation (CPR). However, care plans did not always contain information about people's end of life preferences.

Inadequate

Is the service well-led?

Our findings

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

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

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

- Prior to our inspection, we received concerns that indicated the service was not consistently well-led. At this inspection, we identified multiple breaches of regulations which confirmed the quality and safety of the service had deteriorated since our last inspection.
- The provider had not maintained effective oversight to ensure people received high quality care in a safe environment. We found widespread concerns in areas such as environmental risk management, risks to people's health, medicines management, infection control, recruitment, mental capacity, accident and incident management and nutrition.
- There were limited audits and checks which meant many of the issues we found had not been identified. Opportunities to improve safety and drive forward improvement had been missed.
- Where external agencies identified areas which compromised people's safety, the provider had not acted in a timely way to address the issues which exposed people to the risk of harm.
- The management team had not kept themselves up to date with legislation and best practice. This was because they had failed to initiate and maintain effective practices.
- Providers have a regulatory responsibility to inform the Care Quality Commission (CQC), about significant accidents and incidents that occur within the home. Although one serious injury had not been caused by staff at the home, the registered manager still has a regulatory responsibility to report this to us. The notification was submitted retrospectively following our inspection
- The registered manager was regularly working excessive hours which was unsustainable and had potential to compromise the safety of the service. For example, on the day of our inspection the registered manager had worked a 20-hour shift until 4.00am and had then returned to work at 9.00am to give people their medicines.
- Relatives recognised the commitment of the registered manager, but some did not feel the home continued to be well managed. Some relatives felt emotional responses from the registered manager prevented them from raising concerns.

The above issues demonstrated a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager was open and honest about the difficulties they had faced recruiting staff after long serving members of the team had left. This meant they had spent significant periods of time supporting

people rather than maintaining managerial oversight.
● The provider told us, "There have been many changes in requirements for residential homes, and these are becoming increasingly difficult to fulfil. We have recognised this is largely due to the limitations of the building and understandably the increasing fire regulations." Following our inspection, the provider confirmed they wished to voluntarily close Bancroft Gardens Residential Home due to their retirement and issues connected with the risks associated with the building.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Staff told us that they were able to share their ideas and felt listened to. Staff meetings had taken place regularly. Comments included, "[Registered manager] is very approachable and looks after us" and, "[Registered manager] is a nice lady. She helps us a lot and listens."
● There were limited ways in which the provider sought feedback from people or relatives about the quality of care delivered. One relative told us, "There are no relative meetings and they provide no response to questionnaires."

Working in partnership with others
● The registered manager was working with the local authority to make improvements to the service following a recent quality assurance visit. This included attending provider forums to support them to improve people's experience of care.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider was aware of the need to be open and transparent and share information if things go wrong with people's care and treatment. However, the provider did not have effective systems in place to respond professionally to concerns which had been raised with them.

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 12 HSCA RA Regulations 2014 Safe care and treatment 12 (2) (a) The provider had not assessed the risks to the health and safety of the service users 12 (2) (b) The provider had not done all that was reasonably practicable to mitigate such risks 12 (2) (g) The provider had not ensured the proper and safe management of medicines

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs 14 (4) (a) The provider had failed to ensure nutrition assessments were accurately carried out by a person with the required skills and knowledge. The provider had failed to ensure nutrition needs were regularly reviewed and that any changes in a person's needs were responded to in good time. The provider had failed to ensure nutritional intake was monitored to prevent weight loss. Action was not taken without delay to address weight loss concerns

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment 15 (1) (b) The provider had not ensured the appropriate level of security needed in relation to the service being delivered 15 (1) (e) The provider had not ensured the premises were properly maintained

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance 17 (1) Systems or processes had not been established and operated effectively to ensure compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) 17 (2) (a) Systems and processes had not assessed, monitored or improved the quality and safety of the service provided in the carrying on of the regulated activity 17 (2) (b) Systems and processes had not assessed, monitored or mitigated the risks relating to the health, safety and welfare of service users 17 (2) (e) The provider had failed to actively encourage feedback about the quality of care and overall involvement with them. The provider had failed to always listen, record and respond as appropriate