Westcare (Somerset) Ltd

Friarn House Residential Home

Inspection report

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Date of inspection visit:
04 August 2022

Date of publication:
25 October 2022

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Friarn House Residential home is a residential care home providing accommodation and personal care for up to 16 people. The service supports people who may need support with living with dementia. At the time of the inspection there were 15 people living at the service.

People's experience of using this service and what we found

People told us they were bored and had nothing to do. Comments included; "We need things to do" and "I'd like to go out more." Other comments included; "There is nothing to do. I'm trying to get a coffee, but no-one comes in the lounge" and "Oh my goodness it's so boring. You'll be lucky to see anyone." Also; "There are no staff about."

People looked bored with no interaction, stimulation and little or no staff presence. Systems and processes had not been completed or updated as required. Audits were in place, however they had not been completed and concerns we highlighted on this inspection had not been identified.

There were insufficient staff working with people. There were two staff to care for 15 people. There was no staff dependency tool used to assess how many staff were needed to keep people safe. These two members of staff also had tasks to complete including, laundry, tea round in the afternoon and evening, cleaning after 2pm and at weekends. They also had to prepare supper and had to administer medicines in the morning and evening, which took 40 minutes each time. One care worker said, "I feel awful because I'm trying to hurry and make sandwiches and then I have no time with people." Another said; "I'm very often the only staff member around." One person required full assistance with their personal care, so staff needed to support them with a shower. This took 30 minutes, leaving only one staff available. However, they were also doing the laundry, so people were unsupervised during this time.

A staff member said; "We have raised the lack of staff on the floor many times and nothing happens. Over and over, nothing done" and "This place is like a racing track we go around and around like headless chickens. We don't have any time."

People were at risk due to a lack of care plans and risk assessments. Care plans did not contain information about people's skin integrity. One person was now on an end of life pathway due to the deterioration in their health. No update care plan was in place showing this person's current needs.

One person had no care plan in place. The staff confirmed this and said the person was at risk of falls, used a pressure mat in their room and was living with dementia. No care plan or risk assessment was in place in regard to people who'd had an allergic skin reaction. No care plan or risk assessment was in place for one person who was living with a particular type of dementia. They were continually breaking their reading glasses due to excessive cleaning and repetition and staff had no information on how to minimise this risk.

One person, who was able to make their own hot drink did not have a risk assessment in place so staff could support them to maintain their independence while staying safe.

We found the provider had not reported and investigated possible safeguarding alerts. No up-to-date risk assessment, or referral had been sent to the appropriate people, for example the falls clinic, even though it was documented that one person had fallen 29 times in a little over six months. A body map held in this person's file showed a high number of marks and bruises. On one occasion this person had a bruise and swollen ankle needing hospital treatment. This person then needed to wait 24 hours before being taken to hospital for treatment due to a lack of staff available. No accident form had been completed, it had not been investigated or passed to the local authority's safeguarding team. No notification had been sent to CQC as required. No death notification had been sent to CQC following one person's death.

People did not receive person-centred care. Two people were receiving end of life care in a shared room. They had no interaction from staff other than for tasks and meals. They spent all day lying in bed with nothing to look at. They were known to be friends but could not see each other and did not have any familial items around them.

The main lounge had chairs situated around the edge of the room. People were unable to see or hear the television.

People did not receive person centred care in relation to their continence needs. Continence management was poor meaning people were wearing continence aids which were often soiled when staff checked them. There was no evidence of staff pro-actively supporting people to maintain their independence in this aspect. Staff said they did not have time.

One person was living with a particular type of dementia. This meant they could experience abrupt mood changes, compulsive or inappropriate behaviour, disinterest and depression and repetition. There was no information for staff about this or guidance on how to meet the person's needs.

There were no records of peoples' individual activities. The activity co-ordinator had not had any training in dementia care, and they had not seen anyone's care plan and did not know their needs, likes or preferences. They said; "I worry that I have no training, I just do what I think people will like. It would be nice to have some support. People are all at different levels of dementia."

We found people had little or no interaction and people were left for long periods without seeing staff. Our observations showed there were no staff present for most of the day in the main lounge area and the call bell was out of people's reach. People were put at risk due to lack of staff observation. One person in the lounge area was at a high risk of falls. During our observation people told us they were hungry and thirsty. One person was known to show distress by rocking. For long periods during the afternoon we observed them rocking in the dining room with no stimulation or engagement with staff. One person told us; "We have to shout out if we need help or rely on the person sitting next to us if we need the toilet.'

The only outside area was extremely dangerous with cracked and uneven surfaces. There were many items of broken equipment dumped in the garden, a rotten bird table and unsafe rotten benches. Large amounts of a noxious plant were in the garden and were easily accessible to people. Doors to the garden were left unlocked. People living with dementia and poor mobility were left unsupervised and would be able to access the outside area unobserved which would put them at risk. Due to the low numbers of staff there was no-one to support people to access the garden safely and so they were confined to the building, even during the warm weather.

The internal environment needed updating and attention and some areas were found to be dangerous. The office door leading to the basement was not locked. This meant it was accessible to people and was a risk due to the door leading to steep steps into the basement. The lounge door was a fire door but was propped open.

Bed bases in some rooms were heavily stained, broken and unfit for purpose. Bedrooms were very bare and unloved. Photo frames, paintings and personal items were not placed carefully and paintings were askew. Flannels and towels were all threadbare and the linen room held a minimal amount of extra linen. Sheets and pillows were very thin, and some were ripped. There were no locks on any toilets or bathrooms which did not protect their dignity.

People were unable to access the conservatory area as it was being used as a storage space for a hoist and stand aid.

Medicine audits had not been completed. We could not be sure people received their medicines as prescribed. Some people were prescribed 'as required' pain relief medicines. The protocols in place stated, 'one tablet at night.' However, also recorded was 'up to eight 500mgs tablets in 24 hours' also 'one or two tablets to be given.' Additional information was confusing and contradictory. Staff did not record how many tablets people were given or the time people had received this additional medicine. Therefore, there was no evidence people had been given their maximum pain relief of the up to eight tablets in 24 hours, or that they had been evenly spaced throughout the day. People were also receiving these 'as required' medicines on a regularly basis and not 'as required.' We also found medicines loose in the medicine cupboard and not in the original boxes. The service had a large number of medicines that required additional security, storage and signatures. These medicines were not documented as being held in the service as required. One person was prescribed a medicine that required them to have their blood pressure taken before administration. This had not been recorded as having been taken since March 2022.

There was no information about people being offered a food choice or involved in any menu planning. We were told by staff that they only had a budget of £3.00 to £3.50 a day to spend on each person's food. Staff said it was 'difficult to buy quality food' and 'they could never stay in budget.'

People had not been given the chance to feedback on the care and support they'd received. No resident meeting or quality assurance survey had been completed.

Cleaning and infection control procedures had not been updated in line with COVID-19 guidance to help protect people, visitors and staff, from the risk of infection. Not all PPE bins were suitable for use due to not being foot operated pedal bins.

Recruitment processes were followed in line with guidance. People received in house healthcare services, for example the district nurse team was supporting someone with their skin integrity.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported 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 and update
The last rating for this service was good, published on 19 March 2029.

Why we inspected
We undertook this inspection due to receiving information of concern about people's care.
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.

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service.

We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safeguarding, staffing, staff training, medicines, premises, dignity, consent, person centred care, infection control and good governance at this inspection.

We required the provider to report to us on a monthly basis outcomes of audits they had completed of the service.

This service is now closed.

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. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service is 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 caring? The service was not caring. Details are in our caring findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

Friarn House 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
The inspection was carried out by two inspectors.

Service and service type
Friarn 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. Friarn House 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 no registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
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 reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used all this information to plan our inspection.

During the inspection
We spoke with six people who used the service about their experience of the care provided. We spoke with eight members of staff including the acting manager, deputy manager, care workers and auxiliary workers. We also spoke to the newly appointed Clinical area lead.

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

Inadequate

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management

- People were not always protected from risks associated with their health, safety and welfare. People's needs, and abilities were not always individually assessed prior to moving into the service.
- People were at risk due to a lack of care plans and risk assessments in place. This had the potential to place the individual and others at risk of harm. One person who was considered a high risk of falls and was living with dementia had no care plan in place.
- Risk assessments covering areas such as skin integrity, personal care and nutrition had not been updated to reflect people's current needs. No updated risk assessments had been completed after people had suffered a high number of falls or sustained an injury. One person was observed mobilising around the home independently all day. The last fall's risk assessment was held in an old folder dated October 2021. This stated they were a 'high risk'. However, a handwritten note was attached to this risk assessment saying, 'considered low risk despite score'. We observed this person and they were clearly unsteady on their feet. They had little or no interaction or observation.
- People were placed at risk due to the poor maintenance of the service. In particular, the outside space. The large garden had cracked and very uneven surfaces, the garden was used as a dumping ground for broken equipment, including a rotten bird table and, unsafe to sit on rotten benches. Benches could not be used as birds had defaecated onto them and all over the ground. Copious amounts of noxious plants were in the garden. Doors leading onto the garden were not locked and placed people at risk as many people were living with dementia, and would be able to access outside easily and unobserved due to the low numbers of staff. Inside the service we found the lounge fire door propped open and the office door leading to the basement was not locked. This meant it was accessible to people and was a risk due to the door leading to steep steps into the basement. We found broken and heavily stained beds.
- Care plans did not contain information about people's skin integrity Putting them at risk of inconsistent or inappropriate care. For example, one care plan kept in an old file and not being used stated under the heading, 'Pressure sores': 'All clear'. In a separate file which contained the daily records there was a blank body map. However, there was an entry in the professional visits page about the person's sore sacrum with instructions about what creams to use. There were no records of what the sore looked like or whether it was healing.
- People's care plans did not contain sufficient information for staff to be able to support people with their dementia care needs. We observed one person experience periods of distress and anxiety due to living with dementia. They received little or no interaction or observation.

The provider had not assessed the risks to the health and safety of people receiving care. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, referrals had been made under DoLS.

Systems and processes to safeguard people from the risk of abuse
● The service did not have effective systems in place to protect people from abuse.
● We received information that a person had sustained a high number of unexplained injuries, including bruises and sores. This person was also assessed as being at high risk of falls and had fallen 29 times in a little over six months. This person had again sustained unexplained injured and required hospital admission. No information had been recorded on how some injuries had been sustained and none had been investigated or reported to the local safeguarding team. Records showed no professional advice had been sought on how to protect people or prevent any further injuries and falls. No updated care plan or risk assessment had been completed.
●The provider was not fully aware of their responsibilities to raise safeguarding concerns. They had not raised serious safeguarding incidents with the local authority to protect people and had not notified CQC appropriately of concerns.

The provider had not taken appropriate action to investigate or refer suspected abuse to the appropriate organisations. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff said they had completed on-line safeguarding training.

Using medicines safely
● Medicine audits had not been completed. We could not be sure people received their medicines as prescribed.
● Systems for medicines that required additional security were not followed. A large number of medicines requiring additional security when held at the service. However, none had been documented or recorded as held at the service.
● People were prescribed 'when required' medicines. However, the protocols available to guide staff held confusing information. For example, some held contradictory information on the daily dose that could be administered. One stated the dose to be 'once at night' and, further on was recorded 'eight tablets in 24 hours.'
● The medicines administration records (MARs) had recorded for another person, they could receive either one or two tablets of a 'when required' medicine, up to every four hours. From these records it was not always possible to tell whether the person had been given one or two tablets and what time they had received them. This meant people could receive medicines doses too close together or not receive their full pain relief to support them.
● Not all people's medicine support needs had been assessed, and some information was not recorded in

care plans. Care plans did not include additional risks related to medicines. For example, highlighting allergies and reactions to certain medicines. One person had a professional visit entry stating they had an allergic reaction on their arm and were having antihistamines and antibiotics in June 2022. There was no body map or follow up. The deputy manager said this had cleared up.
● Some medicines were not held in their original boxes and were left loose in foil packets. Therefore, there was no information on who these medicines had been prescribed for.

The provider had not ensured the proper and safe use of medicines. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● There were insufficient numbers of staff on duty to meet people's assessed needs.
● There were two care staff on duty to support 15 people. They also had additional tasks to complete including, medicine rounds which sometimes took up to 40 minutes to complete, laundry, cleaning in the afternoons and at weekends, preparing evening meals and coffee and tea rounds. This meant staff could not spend quality time with people or monitor them effectively in order to keep them safe.
● People and staff agreed there were not enough staff on duty to meet people's needs. One person said; "We have to shout out if we need help or rely on the person sitting next to us if we need the toilet." While another said; "We need things to do" and "I'd like to go out more." Other comments included; "There is nothing to do. I'm trying to get a coffee, but no-one comes in the lounge" and "Oh my goodness it's so boring. You'll be lucky to see anyone." An auxiliary staff member commented; "I'm very often the only staff member around so I try to help them." While another auxiliary staff member said; "I'm always helping people out. Never any (care) staff around."
● The staff said they worked additional hours, without pay to help out. No systems were in place to show the number of staff needed to be on shift to keep people safe. One person sustained an injury and had to wait 24 hours to be taken to hospital due to lack of staff.
● Staff were concerned about staffing levels. Staff told us a high number of people required the support of two staff or continual monitoring. This was due to their high risk of falls or people deemed end of life care and confined to bed and needing two staff to attend to their needs. One staff said; "We have raised the lack of staff on the floor many times and nothing happens. Over and over, nothing done." While another said; "This place is like a racing track we go around and around like headless chickens."

The provider had failed to ensure sufficient employed qualified staff were available to provide consistent care. This is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Recruitment practices were thorough and included pre-employment checks from the Disclosure and Barring Service before new staff started work.

Learning lessons when things go wrong
● There was no evidence the service reflected and learnt from issues and incidents when things went wrong. There was limited use of systems to record and report concerns. When things went wrong reviews and investigations were not sufficiently thorough.
● Where changes in people's needs or conditions were identified, prompt and appropriate referrals to external professionals had not always been made. For example, a person had not been referred to the falls team for support in managing their needs.

The provider's governance systems were ineffective in improving the service people received. This was a

breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

- We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. We found the bins holding the clinical waste were not appropriate. They all needed to be opened manually which could be an infection control concern.
- We were assured that the provider was accessing testing for staff.
- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was meeting shielding and social distancing rules.
- 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 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.
- We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

We also signposted the provider to resources to develop their approach.

Inadequate

Is the service caring?

Our findings

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

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

Respecting and promoting people's privacy, dignity and independence

- People were not always supported in a way that promoted their dignity and independence. For example, continence management was poor meaning people were often left wearing continence aids which were soiled. There was no evidence of staff pro-actively supporting people to maintain their independence in this aspect. A staff member told us there were seven people who required support using the toilet. They all wore continence aids.
- One persons' initial pre-admission assessment recorded they had issues with continence management and inappropriate urination. This person was observed moving around the home independently and had a strong odour of urine. We requested a member of staff to support this person. However, staff informed us this person was wearing a continence product and they could not go to assist them as they were busy. Their daily records had no records of regular continence support checks.
- One person's care record stated; 'I do like to go out and about, but I can't do that'. Timed outings were suggested in the assessment but there was no evidence this was happening. This person was on extended respite and not permanently living in the service. Therefore, there was a possibility of living back in the community as part of their plan. This meant it was important they were supported to maintain their independence and confidence when accessing the community.
- Staff told us eight people were unable to use their call bell independently. There were no records of regular checks for these people, some who remained in their own bedrooms or sat in an unattended lounge for long periods. One person said; "There is nothing to do. I'm trying to get a coffee, but no-one comes in the lounge and it's too much effort to get up to use the call bell on the wall."
- People were visibly bored. People had little or no activities. What activities there were had not been planned to suit people's interests and hobbies. Some people were seen to be colouring and playing with early learning toys. Staff designated to carry out activities had no dementia training and had not seen any care plans.
- No consideration had been given to the layout of furniture to support people to interact with each other or watch the television. Lounge chairs were positioned around the edge of the room and people were unable to see or hear the television. One person told us; "Can't see or hear the television." Staff were requested to reposition chairs so people could see the television. After people were moved to a better viewing position, they became visibly more settled and engaged with programmes.
- Staff told us another person enjoyed touch and company. They had no interaction all day other than for tasks and meals. When we spoke with them, they did not want us to leave.

People did not receive appropriate person-centred care and treatment. This was a breach of regulation 9

(person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Another person's care plan stated they required full assistance from staff as they were doubly incontinent. Staff told us this person had a sign that they used if they needed the toilet. We saw this person walking unsupported around the home showing this sign. We guided them to the toilet and found a staff member, but the person had already been incontinent due to the delay in staff support and they then needed to have a shower.
● We were informed that some staff gave inappropriate nicknames to people living in the service. These people did not have capacity to agree to these names. This indicated a disrespectful approach to people.

The provider failed to ensure people received care and treatment in a way that ensures people's dignity and treats them with respect at all times. This was a breach of regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring people are well treated and supported; respecting equality and diversity
● Low staff levels on shift impacted on how people were treated and supported. Staff did not always have the time to spend with people, to listen to them and support them. We observed people sat in one lounge area all morning and from 2pm to 5pm with little or no interaction.
● People were unable to reach the call bell to call for assistance. One person was known to show distress by rocking. They were seen for most of the afternoon rocking in the dining room with no stimulation or engagement with staff. Staff told us this person responded well to distraction and company. One person said; "Nothing to do day after day." While another person said; "There's nothing going on. I have no family. I just walk around from room to room."
● We observed staff sitting outside enjoying a break as it was a very hot day. People had to remain inside the service due to the garden being very unsafe and there being no staff to support them.
● We found sheets, towels, and flannels extremely frayed, ripped and not fit for use
● We observed two people, on end of life care, left in their shared bedroom and confined to bed. The bedroom door was closed. They had no interaction from staff other than for tasks and meals. They spent all day with nothing to look at. They were known to be friends but could not see each other. There were no familial items surrounding them which may have given them comfort and their bedroom looked bare and unloved.
● Some people were unable to express their needs and choices verbally. Their communication needs were not documented. Background information about people's personal history was not always recorded. This mean staff were unable to gain an understanding and engage in meaningful conversations with people.
● People where left for long periods without any interaction or company. We observed this affect on people when we briefly spoke with one person and they showed they did not want the company and interaction to end.

People did not receive appropriate person-centred care and treatment. This was a breach of regulation 9 (person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were not all provided with training in meeting people's care needs or training in their role. For example, one auxiliary staff member had not received any training in dementia care, however they assisted people to the toilet due to a lack of care staff. They said; "I worry that I've had no training."

The provider failed to ensure people received care and treatment in a way that ensures people's dignity and treats them with respect at all times. This was a breach of regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● People were not always supported to make decisions about their daily living. Due to low staffing levels and staff being busy people were unable to speak to staff. One person said; "I'd like to go out more" and "I'd love to go out into town once a week. It's just outside the front door."

● People had no choice on how they spent their time. Some people sat in the lounge and others in the dining room and remained there all day. The conservatory was unavailable due to being full of unused equipment and the gardens where inaccessible due to being extremely unsafe to use.

● There was no evidence people were supported to feedback on their experiences or contribute to how the service was organised. People's views had not been obtained as no meetings or surveys had been completed. Staff where unable to sit down on a one-to-one or in small groups to talk to people due to lack of staff.

● Some care records included instructions for staff about how to help people make as many decisions for themselves as possible. However, staff did not have time to access these records.

People did not receive appropriate person-centred care and treatment. This was a breach of regulation 9 (person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People had information on how to manage their continence needs recorded, but this was not followed. Staff used incontinence products on people as they did not have time to assist people with their individual continence needs. Therefore, people's choice and preferences in relation to the support they received was not followed.

The provider failed to ensure people received care and treatment in a way that ensures people's dignity and treats them with respect at all times. This was a breach of regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

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

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

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

- The provider's systems failed to ensure that people received person-centred care to meet their needs and reflected their preferences.
- We received information from staff that if they complained about the lack of staff they were ignored.
- People did not always receive good outcomes. For example, one person was living with a particular type of dementia. This meant they could experience abrupt mood changes, compulsive or inappropriate behaviour, disinterest and depression and repetitive behaviour There was no information for staff about this or guidance on how to meet the person's needs. One care worker told us about the person's repetitive behaviour but did not know any details about how to meet their needs and demonstrated a lack of understanding of the person's needs or ability to empathise with their situation. The person spent the day unsupervised walking around the home with little engagement other than tasks. They were known to wear glasses but kept breaking them due to repetitive cleaning. They were not wearing glasses during our inspection.
- Some staff informed us they had not received support, all the training they needed, supervision or appraisal, to support them to carry out their duties. This showed a disregard for the quality of staff and therefore the quality of the care and support provided.
- Many staff were unhappy in their role. One said; "I'm leaving. Partly due to the lack of staff. I should have left an hour ago and I'm still doing things", and another said; "We have no time to do anything just run around. It's even worse when we are on our own with agency staff."

The provider's governance systems were ineffective in improving the service people received. This was a breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The service is required to have a manager registered with the Care Quality Commission. A registered manager 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 this inspection the service had not had a registered manager since March 2022. A temporary manager had been in post but left the week before our inspection. A manager from another service was currently overseeing Friarn House. This meant oversight of the service had been inconsistent.

● Systems and processes had not been maintained or updated since the registered manager left. Staff recorded on daily records when some people had fallen. These were not always reviewed as an accident or incident. Not all accident forms had been completed. For example, one person, who was currently in hospital after a fall, had several falls and unexplained injuries recorded in their daily records. Accident forms had not been completed for this person on all the falls and injuries recorded. Therefore, we were not assured management were reviewing all incidents and identifying themes or learning to mitigate the risk of them happening again.
● At this inspection we found some audits had not identified areas for improvements. This meant some improvements had not been actioned to ensure a safe and effective service. For example, the last medicine audits had not identified the concerns found at this inspection. These are detailed in the safe section of this report. Falls audits did not pick up that one person, who was at high risk of falls, did not have any risk assessment in place and had not been referred to the fall's clinic. This meant the audit process was not always effective.
●The provider had a system in place to review people's care plans. These reviews however, had not identified the issues identified at inspection. There were gaps in information and a lack of guidance for staff. Some people did not have a care plan in place. Management of continence and distressed behaviours was poor indicating these areas were not considered as important or central to people's care.
● Audits of the service were not used to improve people's experiences. Due to low staffing levels there was a lack of interaction, stimulation and monitoring. People's needs were not always met in a timely manner. Some people's needs had changed, and information required updating. For example, people who were on end of life care did not have updated information held in their care plans. This meant people were at risk of harm or unsafe care. Audits had failed to identify these shortcomings as areas for improvement.

The provider's governance systems were ineffective in improving the service people received. This was a breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Due to a lack of management oversight, the assessing and monitoring of the safety and quality of the environment was not always carried out or recorded. For example, environmental audits had not been completed to identify that bedrooms were very bare and unloved. Photo frames, paintings and personal items were not placed carefully and paintings were askew. Flannels and towels were all threadbare and the linen room held a minimal amount of extra linen. Sheets and pillows were very thin and some were ripped. Bed bases in some rooms were heavily stained. Some bed bases were broken and unfit for purpose. There were no locks on any toilets or bathrooms used by people living at the service. People left in the main lounge area for long periods were unable to see the television. The garden was extremely unsafe, full of rubbish and held dangerous plants. There was a general air of neglect and the impact of this on people's emotional well-being had not been considered.

The provider had failed to ensure the premises used by people is properly maintained. This was a breach of Regulation 15 (Premises and Equipment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider did not understand their role in terms of regulatory requirements. For example, notifications were not sent to CQC when required to report; incidents, accidents and safeguarding concerns that had occurred. We found safeguarding concerns recorded in people's individual daily records. However, these had not been reported to CQC or forwarded to the local authorities safeguarding team and there had been no follow up with professionals to seek advice to help protect and support people.

The providers did not notify CQC of all incidents that affect the health, safety and welfare of people who use services. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (Notification of other incidents).

● The commission had not received any notifications about people who had passed away.

The provider did not notify CQC of all deaths within the service. This was a breach of Regulation 16 of the Care Quality Commission (Registration) Regulations 2009.

Continuous learning and improving care
● Governance systems were not being used effectively in the service to identify areas that needed improving. Audits and checks of the service had not identified failings.
● There was limited evidence of the provider's ability to drive improvement at the service. Care was predominantly focused on completing tasks such as providing food and medicines. There was limited evidence consideration had been given to people's comfort or emotional well-being. There was a sense these aspects of care were undervalued.

The provider's governance systems were ineffective in improving the service people received. This was part of a breach of continued Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● There was no evidence available to demonstrate people's and relatives' views on performance of the service had been sought.

The provider had failed to establish satisfactory governance arrangements. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others
● Changes in people's needs were not recorded and appropriate referrals for external professional support were not made. These included referrals to the falls clinic for someone who had a high number of falls and contact with continence nurses for people needing additional support in this area.

The provider's governance systems were ineffective in improving the service people received. This was part of a breach of continued Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The new manager had a good understanding of their responsibilities under the duty of candour and intended to ensure people's relatives were kept up to date.
● The new manager was open and honest throughout the inspection process. They recognised significant changes were required to meet people's need and had begun taking action to improve the service's performance.

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 16 Registration Regulations 2009 Notification of death of a person who uses services The provider did not notify CQC of all deaths within the service. This was a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 (1.)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The providers did not notify CQC of all incidents that affect the health, safety and welfare of people who use services. Regulations 2014. (2. 1.) This was a breach of regulation 18 of the HSCA and Social Care Act 2008 (Regulated Activities)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure systems and processes were established to prevent abuse of service users and take appropriate action. Including investigation and referral to appropriate body. This was a breach of regulation 13 of the Health

and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulation 13 (2.)

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 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured people's preferences for their care, the appropriate needs of people was met or carried out an assessment of needs. Regulation 9 (1. a b c) This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We Imposed Positive Conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure people received care and treatment in a way that ensures people's dignity and treats them with respect at all times. Regulation 10 (1) This was a breach of regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The enforcement action we took:

We Impose Positive Conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 12 HSCA RA Regulations 2014 Safe care

personal care	and treatment The provider had not assessed the risks to the health and safety of people receiving care. Regulation 12 (2. a) The provider had not ensured the premises used by people are safe to use. Regulation 12 (2. d) The provider had not taken all necessary action to protect people from infection. Regulation 12 (2. h) This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We Imposed Positive Conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider must ensure the premises used by people is properly maintained. This was a breach of Regulation 15 (Premises and Equipment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 15 (1. e)

The enforcement action we took:

We Imposed Positive Conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not assessed, monitored and improved the quality and safety of the services provided. Regulation 17 (2. a)

	The provider's governance systems were still ineffective in improving the service people received. Regulation 17 (2. b) This was a breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We Imposed Positive Conditions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure sufficient employed qualified staff were available to provide consistent care. Regulation 18 (1) The provider had not ensured all staff received appropriate support, training, professional development, supervision and appraisal, as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (2. a) This is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

WE Imposed Positive Conditions