Rapport Housing and Care

Edward Moore House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Edward Moore House is a residential care home providing accommodation for persons who require nursing or personal care to up to 39 people. The service provides support to older people and people living with dementia. At the time of our inspection there were 31 people living at the service.

People's experience of using this service and what we found
Although the feedback from people living at Edward Moore House and their relatives was mainly positive, we found systems to monitor people's safety and well-being were not robust. Risks were not always identified and acted upon. Accidents and incidents were not effectively reviewed and monitored to minimise the risk of them happening again. Safeguarding concerns were not consistently shared with the local authority and The Care Quality Commission (CQC) to enable thorough investigation. Systems to monitor people's medicines were not robust which meant people may not receive their medicines as required.

People were not always supported by sufficient, skilled staff. Due to staff shortages the provider employed a large number of agency staff who did not know the people or the routines of the home as well as more permanent staff. Staff did not have comprehensive and accurate guidance around people's care needs as records were not updated regularly and contained contradictory information.

People were supported to access support from healthcare professionals. However, the outcome of people's medical appointments was not always added to people's care records. Changes in people's health needs had not always been recorded to give staff clear information about how to support them safely. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

People's care was not planned in a way that centred on the individual and met the needs and wishes of people. There was a lack of activities. People had limited opportunities to go out unless supported by their family or friends.

Systems to monitor the quality of the service people received were not effective. Action plans lacked detail and timescales for completion were not met. Audit systems were not robust and did not identify concerns. The provider did not have adequate oversight of the service and did not ensure staff in positions of responsibility had the induction, training and support they required.

The provider had systems and processes in place to manage complaints. The provider's records of informal complaints were not robust. We made a recommendation about this.

People told us they enjoyed their food. People and their relatives told us that staff were kind and caring in their approach. Comments included, "They are very nice here, all the carers"; "All the care staff are very

friendly and informative"; "I'm all good friends with the staff here. They look after me well" and "The carers are good; they have a nice nature." Permanent staff and agency staff (that had been regularly working at the service) knew people's needs well and individual interactions with people were pleasant. There was a calm atmosphere at the service.

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 11 November 2017).

Why we inspected
This inspection was prompted by a review of the information we held about this service.

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

The inspection was prompted in part due to concerns received about staffing and respecting people. A decision was made for us to inspect and examine those risks, during the inspection further concerns were found and a decision was made to complete a comprehensive inspection.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement and Recommendations
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 and will take further action if needed.

We have identified breaches in relation to risk management, medicines management, safeguarding people from abuse, safe recruitment practice, assessment of needs, staffing training and induction, mental capacity, dignity and respect, person centred care, quality monitoring and improvement and duty of candour at this inspection.

Please see the action we have told the provider to take at the end of this report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will 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.

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

If the provider has not made enough improvement within this timeframe and there is still a rating of

inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Edward Moore House

Detailed findings

Background to this inspection

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

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

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

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

At the time of our inspection there was a registered manager in post, however they had been on long term leave.

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 who commission the service. We also sought feedback from Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. Healthwatch told us they had not visited the service or received any comments or concerns since the last inspection. A local authority commissioner told us they had carried out contract monitoring visits and had given the provider an action plan.

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 nine people who used the service and two relatives about their experience of the care provided. We observed staff interactions with people and their care and support in communal areas. We spoke with 21 members of staff including the nominated individual, deputy manager, senior care workers, care workers including agency staff, maintenance staff, a chef and housekeeping staff. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included eight people's care records and multiple medication records. We looked at five 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.

Systems and processes to safeguard people from the risk of abuse

● People were not always protected from the risk of abuse. When people had come to harm or there had been incidents between people which was a safeguarding concern, these had not always been appropriately identified, reported and dealt with. This had led to further incidents. The local authority and CQC had not been informed.

● Staff told us they felt comfortable to report concerns to the provider and management team. They felt that concerns were taken seriously, and appropriate action would be taken. Staff knew how to escalate concerns to outside organisations such as the local authority safeguarding team and CQC if necessary. One staff member said, "If there was abuse, I would report it, I would report to [nominated individual] she would take the necessary steps. I would follow it up, I could report to CQC and I would." However, staff had not always taken action to report safeguarding incidents outside the organisation when action had not been taken.

The registered person failed to protect people from abuse and improper treatment. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

● Although people and their relatives told us they felt safe, many people were not able to vocalise their feelings and views to us. Comments included, "I feel safe here, it's alarmed, sensors everywhere and the quality of the carers"; "[Person] is safe here. [Person] recently had a fall and they were quick to call an ambulance and make sure [person] was ok"; "Definitely safe living here, safe and secure" and "It's not bad, it's safe enough".

Assessing risk, safety monitoring and management

● The management and assessment of risk was poor. Sufficient information and guidance was not provided to ensure staff knew how to reduce risks when providing people's care. The service was using agency staff to back fill vacancies, sickness and leave. At times, four out of seven staff were agency staff. High levels of agency staff, who did not always know people's needs, increased the risk of poor care occurring due to the poor guidance provided to staff. This meant they did not have the information they needed to care for people safely and increased the risk of people receiving poor or inconsistent care.

● People were at risk of skin breakdown as pressure relieving equipment was not set up correctly. We identified one person's pressure relieving equipment was set to support at a greater weight than required. Risk assessments did not guide staff in how to set the equipment correctly and checks were not completed to ensure the equipment was working effectively. A daily bed check form was in place, but staff had not completed it for 21 days. This presented a risk that the equipment would not perform as effectively to protect people from skin breakdown.

● Records for one person who was prescribed thickener for their drinks contained contradictory information

in relation to how their drinks should be prepared to minimise the risk of choking. This was of particular concern due to the high use of agency staff who may need to refer to this guidance. We found the person's prescribed thickener in an unlocked cupboard in the kitchen area. This presented a risk of choking to people should they try to eat the thickening granules.

● Risk assessments contained unclear guidance to staff on how to meet people's needs safely. Risk assessments were missing for certain medicines in peoples care records. These included medicines such as novel oral anticoagulants (NOACs) or other anti-coagulant medicines that may increase the risk of bleeding following a fall. Three people prescribed these had been assessed as at risk of falls. There is an increased risk of internal bleeding following a fall on these types of medicines. One staff member told us, "I wouldn't know who is on apixaban or blood thinners, it is reported to the seniors when people fall."

● Personal emergency evacuation plans (PEEP's) did not provide the detail for staff or emergency services to understand people's specific needs to evacuate safely. PEEPs did not specify that people required equipment to take them from the upper to lower floor. Not all staff had attended a fire drill in the last 12 months, there was a lack of management oversight in relation to fire drills. This increased the risk people would not be supported in a safe manner in accordance with their assessed needs.

● Building related risks had not always been well managed. Fire tests showed that a set of fire doors that had been recently installed were not automatically closing as they should. No action had been taken to resolve this. The provider had not ensured that timely and appropriate action had been taken when hot and cold-water outlets were not at safe temperatures. Cold water outlets being too warm can cause the growth of legionella bacteria. This put people at risk of harm. Records showed this had been a continuous issue since 2020. We reported this to the nominated individual who arranged for some action. After the inspection, we received information to evidence that the action had not been successful to resolve the problem.

● During the inspection we witnessed an agency staff member carrying out a moving and handling task with a person that put them at risk of harm. We reported this to the nominated individual who reported this to the agency.

The provider has failed to manage risks relating to the health, safety and welfare of people. 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

● We looked at three staff files to review their recruitment records. We found there were gaps in the employment histories in two of the three files. These had not been explored during the recruitment process, including at interview. The provider had not ensured only suitable candidates were employed to work with people living at Edward Moore House.

● Agency proforma records, to show the agency staff working had been suitably vetted, to provide assurance they had the necessary checks to evidence they were suitable to work with people at Edward Moore House had not always been requested from the agency. Checks were not in place for five agency staff working during the inspection.

The registered person failed to ensure that persons employed were of good character and to ensure recruitment procedures were operated effectively. This is a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● DBS checks had been undertaken and references had been followed up before permanent staff started working at the service. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

● There were sufficient numbers of staff during the inspection to meet people's needs. There was a high volume of agency staff used due to a high number of staff vacancies and staff absence. The provider had not always deployed staff to meet people's needs effectively. On the night of 28 September 2022, no senior care staff had been deployed on shift, which meant there were no trained staff to give medicines. This meant people requiring medicines had to wait until the morning to receive these. One person had been agitated and distressed overnight and was prescribed PRN medicine for this, they were given this medicine at 06:00 when the senior care staff came on shift.
● Despite the concerns we found, people told us "I feel safe, there are plenty of people around"; "If I need anybody in the night, I use the bell and they come quickly" and "I feel there are enough staff here. They are there when I need them."

Using medicines safely
● Medicines were not managed safely. Medicines were not disposed of and returned following national guidance for 'Managing medicines in care homes.' This meant the provider could not account for all medicines in stock or those that had been returned.
● Topical medicines records showed people had not always been given their topical medicines in line with prescriber's guidance. One person was prescribed ointment and a gel. The medicines administration chart (MAR) showed the ointment should have been started on 20 September 2022. Both MARS for the ointment and gel were unsigned, as were the topical medicines records. This meant the provider could not be assured the person had received their medicines as required.
● Where people were prescribed patches to place on their skin, for example, to control symptoms of Alzheimer's disease, were not administered following prescriber's guidance. The prescriber's guidance was not to reapply the patches to the same area of skin for longer than 14 days. Patches can cause irritation to the skin if they are placed in the same position after removal. There was a risk people, who may already have frail skin, could experience a reaction and discomfort. We found no evidence that people had been harmed.
● Some people needed medicines on a 'as and when' (PRN) basis, for example pain relief. We found there was not always guidance for staff to follow, to check if the medicine was effective, or to make sure the maximum dose of the medicine in a 24-hour period was not exceeded. This increased the risk people might not receive their medicines when they needed them or according to the prescribing guidance.
● Where PRN protocols were in place for people that were prescribed laxative medicines, the PRN protocols were not detailed enough to provide information to staff about when to give the medicine, such as after how many days of no bowel motion should the medicine be given. Although there were entries in continence care plans to state that people were prescribed laxatives, the care plans also did not state after how many days of no bowel motion should the medicine be given. This meant people were at risk of constipation.
● Although regular counts of people's medicines had taken place, these checks highlighted that stocks of medicines did not always tally. Medicines incidents and investigations had not been carried out to determine what had gone wrong. This meant the provider could not be assured that people had received their medicines safely. There was a clear risk people may not have received their medicines as prescribed.

The registered person failed to manage medicines safely. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● We were somewhat assured that the provider was using PPE effectively and safely. We observed one member of staff not wearing a mask appropriately, we spoke with them about this and reported it to the nominated individual.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of

infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● Relatives told us they were able to visit their loved ones whenever they wanted. We observed people receiving visitors during the inspection.

Learning lessons when things go wrong
● The management and oversight of incidents and accidents was poor and had not been used as an opportunity for learning lessons to mitigate future risks.
● Some incidents identified during the inspection had not been recorded or reported. Where they were, sufficient information was not documented, and investigations were not undertaken by the management team to identify how the incident had happened and what they could do to prevent it happening again.

Requires Improvement

Is the service effective?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- People's needs were assessed prior to them moving into the service. However, information gained during the assessment was not always fully captured within care plans. Assessments were not robust enough to identify a clear picture of people's health and care needs. The provider used nationally recognised assessment tools to identify and review people's needs. One person had been assessed using a Malnutrition universal screening tool (MUST). The MUST assessment had not been fully completed and the person had not been referred to a dietician (which they required). Pressure sore risk assessment screening tools (Waterlow) had not always been accurately completed to calculate people's pressure risk.
- Best practice guidance was not always followed. Oral Health Care for Adults in Care Homes had not been implemented. People's oral health care needs were not routinely assessed, and care plans did not give detailed information in relation to people's needs in this area. Staff had not completed training in supporting people with their oral care.
- People's needs were not consistently assessed using recognised tools to monitor risks of falls. Where these were completed the information was not used to inform and review care plans and risks assessments. For example, where people experienced falls their care plans and risk assessments in this area were not automatically reviewed. This meant people were at risk of avoidable harm due to the care needs not being continually reassessed.
- People's needs were not reassessed when their health deteriorated. One person's medical notes showed that they had been taken into hospital after having a seizure in December 2021. The person was not known to have epilepsy. There was no record of this within the person's care plans or risk assessments which meant staff did not have all the information they needed to meet the person's health needs.

The failure to assess people's needs and choices and design care and treatment to meet people's preferences and needs is a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- Staff did not always have the training and experience or receive support relevant to the roles they were undertaking. Although staff had received training in their roles this was not always effective. For example, staff had completed training in safeguarding and the mental capacity act (MCA). Despite this, they had not ensured safeguarding concerns were reported to the relevant authority or that capacity assessments and best interest decisions were completed when required.
- Staff did not have the skills and experience to support people safely. Some staff we spoke with had not

completed training to use the emergency evacuation chairs to enable them to safely evacuate people from upstairs in the event of a fire.
● Some agency staff had not been given a good induction when they first worked at Edward Moore House. Records showed several agency staff had been given an induction, however the names and agency details did not match up with the records of agency staff on the rota. The support to agency staff when they arrived for their first shift was inconsistent which increased the risk of people not receiving the care they required. There were no induction records for seven agency staff who had either worked in the week before we inspected or during the inspection.
● Staff did not always receive training in key areas of their role. Staff responsible for preparing food had not always completed training in fluid and nutrition and food safety. Eight care staff were overdue training relating to moving and handling, seven staff were overdue training in relation to working with people living with dementia and five staff had not completed safeguarding adults training.

The failure to ensure staff received a comprehensive induction, training and support relevant to their roles was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● New staff completed an induction which included the Care Certificate. One staff member said, "I am currently doing lots of training and doing the care certificate." The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.

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.

● The principles of the MCA were not followed. Capacity assessments were not always completed for individual restrictions such as bed rails or sensor mats or specific decisions such as having medicines covertly (hidden). Two people's care records evidenced that capacity assessments had been carried out in retrospect after a decision had been made.
● Best interest decisions were not completed where capacity assessments had determined people lacked capacity to make specific decisions. This demonstrated a lack of understanding of the principles of the MCA and meant consideration had not been given to less restrictive options.
● DoLS applications had been made to the local authority as required. However, staff were not aware of conditions in place. One person's records recommended additional considerations of specific areas of their care due to previous concerns. Staff we spoke with were not aware of these conditions and no additional reviews had been completed to assess the persons safety.

The failure to ensure the principles of the Mental Capacity Act were consistently followed was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some people told us they were able to make their own day to day choices about their care. Comments included, "I have choice about what I do and when, that's a good thing" and "I choose to spend most of the time in my room but I can walk around the home if I want to."

Supporting people to eat and drink enough to maintain a balanced diet
● Staff reported that one person liked to eat their meals when no one else was around. We observed this person had been supported to the dining room on 28 September at the same time as everyone else. We observed them refusing food. At the end of the lunch when people were eating puddings, this person then ate a pudding and was given another as they were still hungry. Action had not been taken to ensure the person was given a balanced meal in an environment they were happy with at a time they were happy to eat. This is an area for improvement.
● People told us they enjoyed the food and there was always a choice of options. Comments included, "Food is excellent, always edible"; "Food is very nice. It's all extremely nice. They don't generally give options that far in advance. They will always swap it if you don't like it"; "The food is ok, I eat what I'm given" and "Food is pretty good, they give us a choice."
● We observed people who required foods in different textures such as puree received their meals at the correct texture. Where people required support to eat this was done at the person's own pace. Staff sat with people whilst supporting them and made conversation where appropriate. Food looked and smelt appetising. People were offered opportunities to have more food if they wanted it and different foods if they did not eat the meal they had chosen.

Adapting service, design, decoration to meet people's needs
● The majority of people's room doors did not have names on or anything to help people recognise which was their room, such as pictures or any items of interest. Records showed that sometimes people had been found in other people's rooms. The nominated individual told us that people living with dementia had removed these signs from their doors and other people's doors. This is an area for improvement.
●The service design did not always meet the needs of people living with dementia. Signage to help people orientate around the home was in place in most areas, however there was no signage to direct people to the garden. This is an area for improvement.
● Kitchenettes within the dining and lounge areas on the first floor and ground floor had been recently replaced, as well as bathrooms. There was a redecoration programme underway for communal areas and bedrooms. The garden area was secure and had been designed to enable
people to sit outside should they wish. Surfaces were even and there were areas of shade. One person told us, "I went out in the garden in the summer."
● People were able to access all areas of the home via a lift. Handrails were fitted to support people with mobility issues and doorways were wide to enable wheelchair access. People had access to adapted showers and baths.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People were supported to access support from healthcare professionals. People's records showed people received support from the GP, district nurses, opticians, dental services and emergency services when required.
● People were supported to attend appointments with specialist services as and when required. However,

the outcome of people's medical appointments was not always added to people's care records. Changes in people's health needs had not always been recorded to give staff clear information about how to support them safely.

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

- Before the inspection, we received two whistleblowing alerts which stated that people were being supported to get up washed and dressed by the night staff (which was not their choice) to relieve pressures on the day staff. We carried out an early morning visit to the service and found seven people already up, washed, dressed and in the ground floor lounge at 06:00. All seven were sleeping in the chairs. By 06:15 there were a total of eight people in the lounge on the ground floor. We observed five people already up, washed and dressed in the first-floor lounge at 06:00. Two people were sleeping in the chairs. By 07:44 there were five people sleeping in chairs in the first-floor lounge. People who were up, were not able to tell us they had wanted to get up. During the inspection one person told us, "They get you up about 07:00am. I don't have a choice what time I get up."
- One person had not been treated with dignity and respect. They were observed at 06:05 sat in their armchair in their bedroom on the first floor. They were fully dressed and sound asleep with a blanket around them. We spoke with the night staff on duty who told us that the person had fallen at 03:10 and they had supported them to get washed and changed and transferred to the armchair at that time, rather than supported back to bed. Staff did not confirm why they did not assist the person back to bed.
- People told us staff were kind. Comments included, "The staff are very caring, they show us respect"; "The staff show me compassion" and "The staff are very kind to me."
- Despite these comments, the wide-ranging concerns identified during our inspection did not demonstrate a caring approach which placed people at the centre of their care. The provider had failed to identify and address the deterioration in the standard of support people received. This showed a lack of care and compassion from the provider in supporting people to live in a safe and nurturing environment.

The failure to ensure people were treated with dignity and respect is a breach of Regulation 10 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

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

- People were not always involved in decisions about their care. People had not been involved in developing their care plans. There was little personal information about people in their care records, to enable staff to provide care and support that was individual, taking into account their life until coming to live in Edward Moore House.
- Relatives said they had been involved in planning their loved one's care. One relative said, "I have been involved in my wife's care plan." Another relative told us, "I was involved in mum's care plan and we sat down with mum and went through it all and discussed her wishes."

● Some people told us they were listened to and made choices relating to their care. Comments included, "Staff meet my needs. If you tell them you're short of something they get it. They know what they are doing. It's me that forgets things"; "I usually wake up when I want to get up" and "If I make a suggestion, I feel it would be listened too."

Respecting and promoting people's privacy, dignity and independence

● People's privacy was respected. Staff knocked on people's doors when entering and ensured doors were closed when supporting people with their personal care. One person told us, "They do close the curtains and shut the door when they are in my room."

● Staff understood the need for people to maintain their independence. One staff member told us, "Every resident has different needs, we try and create a home away from home and fit around their routine here. During personal care we gain consent, talk, explain and listen and respect their wishes. We try different ways of explaining for those with dementia, such as showing them and eye contact."

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; End of life care and support

- People's care was not planned in a way that centred on the individual and met the needs and wishes of people. The detail in people's care plans did not provide permanent staff or agency staff with the information they needed to meet people's needs. One person's care plan said they needed assistance from staff to meet their personal care needs including bathing, showering and oral hygiene. There was no further information about which they preferred or how often and no information about the type of support they needed and how they wanted the support to be offered.
- Reviews of people's care were not completed consistently and accurately. For example, one person's care plan stated they needed assistance with transfers and a wheelchair to move around the service. Actions for staff included walking with the person when mobilising with a frame. The care plan had not been reviewed since 08 May 2022. We observed this person required a hoist for transfers and was not able to walk with a frame. This was of particular concern due to the high number of agency staff being employed who would not have comprehensive information to refer to.
- One person's care plan showed that they were at risk of skin breakdown. There was no further information about how staff should work with the person to prevent skin breakdown, what equipment was in place and what checks on the equipment were required. This put the person at risk of receiving care and support that did not fully meet their needs.
- Care plans to detail the care and support needs of people in relation to sleeping and night care were not clear about preferences and choices. For example, preferred times to go to bed, wake up, how many pillows the person preferred and whether they wanted a light on.
- Edward Moore House was not actively supporting anyone at end of their life. A person was reaching the end of their life and had been prescribed anticipatory medicines.
- Some people had a care plan for their end of life. Some were basic and provided limited information for staff to know exactly what people's wishes were if their health suddenly deteriorated. Basic detail was included, however, a person-centred approach to ensure people's wishes were put into effect and followed as soon as possible was not in place.
- Some people had DNACPRs (do not attempt resuscitation) in place which had been discussed and agreed with them, their relatives and consultants and the GP. There were some issues with DNACPR's. For example, one had not been fully completed and so the date was missing. One had a person's previous address on and conflicted with the person's care file. For example, it stated that they had capacity to make the decision. However, their care records showed they lacked capacity to make complex decisions.

The failure to ensure people received personalised care in line with their needs and preferences was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

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

● The accessible information standards were not followed. Details in relation to people's communication were not always detailed such as how to support people when making choices. Where people found verbal communication difficult there was a lack of information for staff in relation to people's body language and other indications about how the person may be feeling. Guidance in relation to people's dementia and how this impacted on their communication was not considered. People's care plans and most information (such as relevant procedures, information and advice) were not available in accessible formats such as easy read, pictorial and large print.

The failure to ensure people received personalised care in line with their needs and preferences was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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
● Some people told us there was a lack of planned activities. Comments included, "Nothing much happens here, nothing different each day" and "There are no activities here." One person said, "They have bingo and the have dancing on Saturday."
● There were limited activities for people to take part in and no activity programme in place. The management team told us that a member of activity staff had recently been employed and had only been in post for a few weeks. The new activity staff member was planning themed events for people such as Halloween and Christmas parties.
● During the inspection the activities staff member supported some people to sing and dance and some people made cards with art and craft materials. The service had a lifelike baby doll which some people took an interest in. Lifelike dolls can have great benefits for some people with dementia, the sensation of holding a doll can be soothing. It might remind them of a time when they had young children of their own.
● People sat in lounge areas and spent the majority of their time sleeping or looking at the television. In one lounge the television was playing cartoons which no one was watching or showing any interest in. One person's care record showed that they had not taken part in activities since 14 June 2022. Their care plan stated that the person tends to sleep if they are bored. We observed this person sleeping a lot during the inspection. This is an area for improvement.

Improving care quality in response to complaints or concerns
● The provider had systems and processes in place to manage complaints. People had information about how to complain should they wish to. Complaints information was on display on the provider's website and in the service. However, the complaints information was not available in easy to read formats to help people understand.
● The provider had received one formal complaint in 2022, records showed that it was responded to and resolved on the day it was received. The provider's records of informal complaints were not robust. A note was made on the complaints system to show an informal complaint had been received on 13 September

2022. There was no record of what had been done about the complaint and who was dealing with this. The nominated individual was unaware of the complaint as it had been dealt with by another staff.

We recommend the provider consider current good practice guidance on effective complaints management.

● People and relatives told us, "If I raised a concern I feel they would deal with it correctly, haven't had any need to though" and "If I had any concerns I would write to head office in Rochester."

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; Continuous learning and improving care

- There was a lack of provider leadership and oversight. Some limited management support had been provided since August 2022 as a result of an inspection at one of the provider's other local services. A staff member said, "The support has only ever been over the phone. There has been no physical person in the building. More recently since the sanctions there has been some support from [staff member from head office] and the consultant has been in a few days a week over the last month. It has been difficult and I have constantly asked, chased and followed this up and am still waiting for support."
- The provider carried out limited checks to assure themselves that staff were providing care that was safe. We found that care was not safe. We found that people were not provided with care that was of good quality.
- We found many areas of serious concern during the inspection and these had not been identified by the provider. Care plans and risk assessments did not provide sufficient information about individuals to make sure people received good care that was safe. These had not been all been checked by the management team. The oversight of accidents and incidents by the provider was ineffective. Incidents such as personal safety concerns had not been appropriately responded to, which meant prevention plans had not been created to prevent incidents reoccurring. People who were meant to have their weight checked weekly or monthly were not consistently supported with this.
- Records were disorganised and did not contain a detailed description of the care people needed or received. Daily notes were handwritten and sometimes difficult to read. Information was generic rather than including information about how people had spent their time, any concerns or things people had enjoyed. The design of the care plan meant that if there were any changes staff were required to re-write the whole plan. This led to staff adding changes to the review page which presented contradictory information and guidance.
- Records relating to food and drink people had consumed were poor and inconsistent. Records did not always detail the food people had eaten, and how much fluid people had drunk. Some fluid records had been filled in incorrectly, we reported this to the nominated individual who spoke with staff about this. It was not clear from the food records who had received fortified food (where extra nutrients had been added to it).
- The provider had no process for sharing learning from other inspections carried out at their other services to drive improvement across all services. Similar themes regarding care plans, risk management including choking risk, medicines management, staffing, safe recruitment practice and mental capacity and DoLS had emerged during this inspection. A staff member told us, "There have not been any meetings with managers

to share the outcome of the other inspections with the wider management team, I can't remember the last time we had a management meeting. No reports from the other inspections had been shared, I saw them first on Kent online."

● The provider had failed to ensure the Care Quality Commission were notified of significant events within the service in line with their statutory responsibilities. This included incidents between people living at Edward Moore House and other safeguarding concerns. This meant we were unable to effectively monitor risk and the actions taken.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● Feedback received about the quality of the service people received was not shared with people or their relatives. Quality surveys had been given to people and their relatives in 2022. The management team had collated the results of the surveys but had not acted on the feedback and shared the results of the survey. We raised this with the management team and they told us they were going to arrange some meetings with people and relatives.

● 'Resident' meetings had not taken place at the service since January 2022. People did not have regular opportunities to provide feedback about their care and support. People said, "I've never been asked for my feedback"; "I've never been asked to a resident meeting" and "I'm not asked for input."

● Staff meetings were not regularly held. There was no evidence the provider had attended staff meetings at Edward Moore House. Staff told us they received little support from the provider and senior management team. One staff member said, "Head office have given us letters of thank you and cards but no support in person." Another staff member told us, "Communication hasn't been consistent, everything is thrown at you without the support and guidance to do it."

The failure to operate a robust quality assurance process to continually understand and have oversight of the quality of the service and ensure any shortfalls were addressed. The provider failed to maintain accurate and complete records in relation to the service and people's care. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Despite the negative feedback about the lack of support from the senior management team. Staff working at the service were positive about the management team within the service. Staff told us, "I get very good support to do the job, [deputy manager] listens to you and if she can help and take action, she does everything she can"; "I can't fault with the management team, they have been very supportive" and "I feel supported by the manager."

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 had a duty of candour policy in place. However, they had not ensured the management team were aware of their responsibilities in relation to this. We identified an incident which had occurred where a person had left the building unnoticed. This met the threshold of a duty of candour incident. There were no records in place to evidence that the provider had formally met with the person and their relatives to discuss what went wrong and there was no record of an apology. The nominated individual told us they had dealt with the incident in an informal way and it had not been recorded.

The failure to be open and transparent with people and their relatives following a notifiable safety incident is a continued breach of Regulation 20 (Duty of candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. The provider had displayed a copy of their rating in the service and on their website.

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

● People and their relatives were not all aware of who the manager was. Comments included, "I know the home manager. I know them by sight. I don't see them much"; "I've never met the manager. They aren't based here"; "I'm not sure who the manager is" and "I haven't a clue who the manager is."

● Written compliments had been received through a care home online review website. The most recent one read, 'Mum came to Edward Moore initially for respite care at the end of the first pandemic lockdown. The care she received there was exemplary and, given her condition and needs decided that staying permanently was definitely in her best interests. The staff did all they could in what were difficult times with all the lockdown restrictions, and between our visits and phone calls, we managed to keep in touch with Mum. The staff are all very professional and nothing is too much trouble for the residents, with staff often going the extra mile to help out.'

● There was a calm atmosphere at the service. Staff told us they enjoyed coming to work. One staff member said, "I really enjoy my job." Another staff member said, "It's my first job in care, I love it wish I had done it sooner."

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 has failed to assess people's needs and choices and design care and treatment to meet people's preferences and needs. The provider has failed to ensure people received personalised care in line with their needs and preferences. Regulation 9 (1)(3)

The enforcement action we took:

We imposed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider has failed to ensure people were treated with dignity and respect. Regulation 10 (1)(2)

The enforcement action we took:

We imposed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider has failed to ensure the principles of the Mental Capacity Act were consistently followed. Regulation 11(1)(3)

The enforcement action we took:

We imposed a condition on the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider has failed to manage risks relating to

	the health, safety and welfare of people and failed to manage medicines safely. Regulation 12 (1)(2)

The enforcement action we took:

We imposed a condition on the provider's registration

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 has failed to protect people from abuse and improper treatment. Regulation 13 (1)(2)(3)(4)

The enforcement action we took:

We imposed a condition on the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to operate a robust quality assurance process to continually understand and have oversight of the quality of the service and ensure any shortfalls were addressed. The provider failed to maintain accurate and complete records in relation to the service and people's care. Regulation 17 (1)(2)

The enforcement action we took:

We imposed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider has failed to ensure that persons employed were of good character and to ensure recruitment procedures were operated effectively. Regulation 19 (1)(2)(3)

The enforcement action we took:

We imposed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The provider has failed to be open and

	transparent with people and their relatives following a notifiable safety incident. Regulation 20 (1)(2)(3)

The enforcement action we took:

We imposed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider has failed to ensure staff received a comprehensive induction, training and support relevant to their roles. Regulation 18 (1)(2)

The enforcement action we took:

We imposed a condition on the provider's registration.